Blue Cross of Idaho®

Benefit Change Request

Your name (first, initial, last) _____ Blue Cross of Idaho ID Number _____

Home Address (street or route) _____ City, State, Zip Code _____

Name of Employer _____

☐ Check here if address is new

Employee:

Please change benefit coverage from current to _____

Enrollee Signature _____ Date _____

- *If adding or deleting dependents, please complete a new application.*

Group Representative:

Group No. _____

Has change been noted on group billing? ☐ Yes ☐ No

Has payroll deduction been adjusted? ☐ Yes ☐ No

Effective date of change: _____

Group Representative Signature _____ Date _____