MEMBER REQUEST FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Effective Date: _____ / _____ / _____

Subscriber Name: _____

Subscriber ID #: _____

Request a dependent be split or removed from your plan, change your deductible, or cancel your policy using this form below.

Subscriber Name:			
☐ CHANGE DEDUCTIBLE TO: _____	☐ CANCEL POLICY, WRITE-IN REASON: _____		
Confirm address and phone number:			
Name:			
Street Address:	City:	State:	ZIP Code:
Phone:			

Fill out this section when applicable to a requested change.

Member Name:			
☐ SPLIT OFF	☐ TERM MEMBER, WRITE-IN REASON: _____		
Address to send plan information and new invoices to:			
Name:			
Street Address:	City:	State:	ZIP Code:
Phone:			

_____ _____ / _____ / _____

Subscriber Signature Date

_____ _____ / _____ / _____

Dependent Signature Date

**Only required for Split off*

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