BlueCross BlueShield of Mississippi

It's good to be Blue.

MILITARY STATUS CHANGE FORM

For Group or Individual Health Insurance

Specific laws regarding insurance apply to individuals who are ordered to active duty. Use this form to give us information about any covered person (subscriber or dependent) who has military orders to active duty for more than 30 days or for an undetermined period of time.

Return the form to:
Correspondence Control Unit
Blue Cross & Blue Shield of Mississippi
3545 Lakeland Drive
Flowood, MS 39232

SECTION A: PERSON ON ACTIVE DUTY

Name: ______________________ SSN: ____________ Date of Birth: ________
Last First M.I.

Address: ______________________ Daytime Phone Number: ____________
City State Zip

Policy Type: ☐ Individual ☐ Group Group or Policy Number: ____________

If group, group name: ______________________

Status: ☐ Covered Subscriber ☐ Covered Dependent Military Activation Date: ____________

SECTION B: ACTION REQUESTED

☐ Terminate all coverage.
☐ Continue all coverage.
☐ Terminate Subscriber/Continue dependent coverage.

List all members whose coverage will continue.

Self
Name: ______________________
Last First M.I.

SSN: ____________ Sex: ☐ M ☐ F Date of Birth: ____________

TRICARE Coverage: ☐ No ☐ Yes Policy No.: ____________ Effective Date: ____________

Spouse
Name: ______________________
Last First M.I.

SSN: ____________ Sex: ☐ M ☐ F Date of Birth: ____________

TRICARE Coverage: ☐ No ☐ Yes Policy No.: ____________ Effective Date: ____________

Dependent 1
Name: ______________________
Last First M.I.

SSN: ____________ Sex: ☐ M ☐ F Date of Birth: ____________

TRICARE Coverage: ☐ No ☐ Yes Policy No.: ____________ Effective Date: ____________

SECTION B: ACTION REQUESTED

(continued)

Dependent 2

Name: ______________________________
Last First M.I.

SSN: ______________ Sex: ☐ M ☐ F Date of Birth: ______________

TRICARE Coverage: ☐ No ☐ Yes Policy No.: ______________ Effective Date: ______________

Dependent 3

Name: ______________________________
Last First M.I.

SSN: ______________ Sex: ☐ M ☐ F Date of Birth: ______________

TRICARE Coverage: ☐ No ☐ Yes Policy No.: ______________ Effective Date: ______________

If returning from active duty, what is your date of deactivation? ______________

☐ Reinstate coverage on self only, on the deactivation date.

☐ Reinstate coverage on self and dependents, on the deactivation date.

You must supply us with a copy of your orders releasing you from active duty.

SECTION C: OTHER INSURANCE

Are you or a covered dependent also covered by Medicare? ☐ **Yes** ☐ **No**

"A" Effective Date: ______________ "B" Effective Date: ______________

If yes, beneficiary's name: ______________ Relationship: ☐ Self ☐ Spouse ☐ Child

______________ Relationship: ☐ Self ☐ Spouse ☐ Child

Reason for Entitlement: ☐ Age ☐ ESRD ☐ Disability

Do you or a covered dependent have other insurance? ☐ **Yes** ☐ **No**

Name of individual with other insurance: ______________

Relationship: ☐ Self ☐ Spouse ☐ Dependent Type of Policy: *(medical, dental, etc.)* ______________

Name of Company: ______________

Policy Number: ______________ Effective Date of Coverage: ______________

Signature: ______________
Employee/Subscriber

Date Signed: ______________

FOR OFFICE USE ONLY

Reviewed By: ______________

Processed By: ______________

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.