## INDIVIDUAL PLAN CHANGE REQUEST FORM

**Date ___________________**

**Member name _____________________________________________**

**Member ID # ______________________________________________**

### Select a new plan:

Effective July 2012, please change my current plan to the plan I have indicated below. I understand that there are coverage and deductible differences between the plans, and I have noted these differences.

### PLAN OPTIONS

**_____ HMO $15 Copay**

**_____ HMO $20 Copay**

**_____ HMO $30 Copay**

**_____ HMO $1500 Deductible**

**_____ HMO $2500 Deductible**

**_____ HMO $5000 Deductible**

**_____ PPO $30 Copay**

**_____ PPO $2500 Deductible**

**_____ PPO $5000 Deductible**

**_____ PPO $3000 HSA**

**_____ PPO $5000 HSA**

**_____ PPO $8000 Deductible**

I understand that if at some future date I wish to change back to the plan in which I was enrolled prior to this change, the change may require medical underwriting.

### Remove dependents:

**Name of dependent(s) you are removing: _____________________________________**

**Relationship to dependent(s) you are removing: ________________________________**

**Member signature _________________________________ Date ____________**

**Spouse signature __________________________________ Date ____________**

### Submit your completed form:

**By mail:**
Independence Blue Cross
P.O. Box 41452
Philadelphia PA 19101

**By fax:**
215-238-7067