



BlueCross BlueShield of Mississippi

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, P.O. Box 1043, Jackson, MS 39215-1043.

SECTION A: PERSON ON ACTIVE DUTY

Name: Last First M.I. SSN: Date of Birth:

Address: City State Zip Daytime Phone Number:

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: _____