Blue Cross Blue Shield Health Insurance Change Form

Albert Lea School District

Effective Date of Change _____

EMPLOYEE INFORMATION

Last Name _____ First Name _____

Date of Birth _____ Telephone _____

Address _____

City _____ State _____ Zip _____

MEDICAL PLAN CHANGE

From plan _____

To plan _____

DROP COVERAGE

Entire Plan _____

Dependents _____

ADDITIONS TO COVERAGE

Birth _____

Marriage _____

Loss of Coverage _____

Other _____

DEPENDENT INFORMATION

Last Name	First Name	Sex (M/F)	Date of Birth	Relationship to Employee	Social Security #	Disability (Y/N)

Do any of the dependents listed above reside at a different address from the employee?

If yes, list dependents and their address:

At the effective date of coverage, will you or your dependents be insured by any other Health Insurance company?

If yes, please complete the coordination of benefits form found at bluecrossmn.com

I understand that providing false information or omission of relevant information in this application may result in the denial of claims or cancellation of coverage:

Signature of employee _____ Date _____

Please return form to Kaley Grisim in the Business Office.

507-379-4813 kaley.grisim@alschools.org