

# GROUP CHANGE FORM

## Health Benefits

PLEASE INDICATE BELOW ALL ELIGIBLE EMPLOYEE STATUS CHANGES

NOTE: IN ORDER FOR CURRENT MONTH'S CHANGES TO REFLECT ON YOUR NEXT BILLING, THIS FORM MUST BE IN OUR OFFICE NO LATER THAN 20 WORKING DAYS PRIOR TO THE DUE DATE OF THAT BILLING.

**REMIT TO: Regence BlueCross BlueShield of Utah**  
**P.O. Box 30009**  
**Salt Lake City, Utah 84125-0009**

Group Name .....	Total Per Billing Number	\$ .....
Billing Date .....	Less Total of Decreases	\$ .....
	Subtotal	\$ .....
	Plus Total of Increases	\$ .....
	Amount of Remittance	\$ .....

Group Number	Contract Number	Name of Subscriber	Comments	Code*	Amount Decreased	Amount Increased
<b>TOTAL</b>					\$	\$

**\*CODE:**

<p>LE — Left employment or association with group.</p> <p>CANCEL — Still employed by or associated with group. Request to terminate coverage.</p> <p>CH — Change in Rate. If change form (Form E-27) not previously sent to Regence BlueCross BlueShield of Utah, submit fully completed change form.</p>	<p>NEW — New Subscriber. If application form not previously sent to Regence BlueCross BlueShield of Utah, submit complete application form.</p> <p><b>NOTE:</b> Make certain all new application forms and change forms are submitted according to your group's regulations.</p>
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