

## Application for a Transfer of Coverage

When underwriting is not required to change coverage, the Application for a Transfer of Coverage can be used by members with BlueChoice, BlueChoice Plus, BlueDirect, and BlueEdge Individual HSA plans. Use this form to:

- Transfer a dependent to his/her own policy by dependent's choice, or in the event of divorce or death of the primary insured
- Transfer a dependent reaching the limiting age of 25 to his/her own policy
- Transact a "downgrade" to reduce premium (e.g., increase deductible and/or transfer to a plan with less extensive benefits)

Please fax this form to Hallmark Membership at the number on the top of the form. The application will normally be processed within 15 days. The new policy will be effective on the next monthly renewal date following Hallmark's receipt of the form.

# Application for a Transfer of Coverage

When Underwriting is Not Required: downgrades; transfer dependent to own policy  
QUESTIONS? Call 1-866-236-1702 FAX COMPLETED FORM: 1-800-279-7419



Blue Cross and Blue Shield  
of New Mexico

## PART 1 – COVERAGE APPLYING FOR (Please select only one plan box and one deductible box)

**Dependent/Spouse Coverage or Deductible Change** (Only available if currently enrolled in one of these plans):

- BlueChoice \$20, Choose Deductible:  \$250 ...  \$500 ...  \$1,000 ...  \$2,000
- BlueChoice \$30, Choose Deductible:  \$250 ...  \$500 ...  \$1,000 ...  \$2,000
- BlueChoice Plus, Choose Deductible:  \$250 ...  \$500 ...  \$1,000 ...  \$2,000 ...  \$5,000

**Plan Change or Deductible Change** (If not currently enrolled in one of these plans, use standard Application M587):

- BlueDirect Plan A, Choose Deductible:  \$100 .....  \$250 .....  \$500 .....  \$1,000
- BlueDirect Plan B, Choose Deductible:  \$250 .....  \$500 .....  \$1,000 ....  \$2,000 ..  \$5,000
- BlueDirect Plan C, Choose Deductible:  \$500 .....  \$1,000 ...  \$2,000 ....  \$5,000
- BlueEdge HSA\*, Choose Deductible:  \$1,200 ...  \$1,700 ...  \$2,600

\*The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

## PART 2 – PRIMARY APPLICANT INFORMATION

### A. PRIMARY APPLICANT (person applying for change in coverage)

Name \_\_\_\_\_ Spouse (if applicable) \_\_\_\_\_  
 Street Address \_\_\_\_\_ Spouse's Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 City \_\_\_\_\_, NM ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Applicant's Work Phone \_\_\_\_\_

**B. TOBACCO-USE STATUS** Have you, your spouse or your adult dependent child, if insured, smoked cigarettes or used tobacco in any form in the last 12 months? **You?**  Yes  No **Spouse?**  Yes  No **Adult Dependent?**  Yes  No  
(An adult dependent is your eligible child who is 18 years or older.)

### C. PRIMARY POLICYHOLDER OF CURRENT POLICY \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy No. \_\_\_\_\_

**D. DEPENDENT CHILDREN** NOTE: You may only change coverage for children who are now covered under the current Blue Cross and Blue Shield of New Mexico health insurance policy. List all children this application applies to.

Names of Unmarried Children	Age	Names of Unmarried Children	Age
_____	_____	_____	_____
_____	_____	_____	_____

**E. BILLING ADDRESS** If the billing address is different from above, please print it here: \_\_\_\_\_

## PART 3 – REPRESENTATIONS AND ACKNOWLEDGEMENTS

I apply for coverage as indicated for which I am eligible with Blue Cross Blue Shield of New Mexico (also referred to as Company).

I represent that the information provided here as well as the statements included on my most recent application are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on my most recent application or on this Application for a Change in Coverage may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Primary Applicant's or Guardian's Signature Date Signed  
 (if Primary Applicant is Under the age of 18)

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Spouse's Signature (only if spouse is currently covered and wishes to be covered under the new plan) Date Signed

**Dependent(s) Signature(s)** (only if dependent is 18 or over, currently covered, and wishes to be covered under the new plan):

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Signature Date Signed

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Signature Date Signed

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Signature Date Signed

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Signature Date Signed

**PROXY** The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any success of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meetings and any adjournments thereof. The annual meetings of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 20 or more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
 Primary Applicant's Signature Date Signed

**X** \_\_\_\_\_  
 Print your Name as You Signed it

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.