TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

Print Form

Request for Change

☐ Changes/Petitions ☐ Follow up

GENERAL INFORMATION	
Group/Sponsor Number:	Group/Sponsor Name:
OrgPolicy:	Telephone:
Contract Number:	Insured Name:

☐ I. CHANGE TO MAIN HOLDER INFORMATION

☐ Name:

☐ Address:

☐ Telephone:	☐ Date of Birth (mm/dd/yy):	☐ Gender: F ☐ M ☐

☐ II. SOCIAL SECURITY NUMBER CORRECTION

Name:	Incorrect:	Correct:

☐ III. ORGPOLICY/SECTION CHANGE

From (Current):	To:	Effective Date (mm/dd/yy):

☐ IV. COVERAGE CHANGE ☐ Add ☐ Cancel

Name	Contract Number	COVERAGE (S) (select with "X")				
		Basic	Dental	Pharmacy	MM	Supplemental
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

☐ V. ADD DEPENDENT (S) OR CHANGES TO DEPENDENT INFORMATION

☐ Direct ☐ Couple ☐ Optional

Name	Relation	Gender	Date of Birth (mm/ dd/ yy)	Social Security	Basic Coverage	Additional Coverage			
						D	Rx	MM	C
		▼	▼ ▼ ▼		☐	☐	☐	☐	☐
		▼	▼ ▼ ▼		☐	☐	☐	☐	☐

☐ VI. CANCELLATION ☐ All insured ☐ Dependent (s)

Name	Contract Number	Cancellation Date (mm/ dd/ yy)	Reason
		▼ ▼ ▼	
		▼ ▼ ▼	
		▼ ▼ ▼	

☐ VII. CONVERSION: ☐ Yes Telephone: ☐ No

☐ VIII. ID DUPLICATE

Name	Contract Number

☐ IX. OTHER

_____ Group Administrator Signature

_____ Insured's Signature

_____ Date

INSTRUCTIONS

The purpose of this form is to facilitate the insured's request for changes, additions, cancellations and/or other petitions. Please make the proper selections and fill out the spaces required. Triple-S Salud will proceed to change this information of the record with marked (X) options or the information you indicate. Some changes are allowed only in predetermined periods, or with certain specifications. Please consult your policy.

GENERAL INFORMATION

Include the group and insured information required and any document(s), if requested.

I. CHANGES TO MAIN HOLDER INFORMATION

Use for changes or corrections in the name, date of birth and/or gender. Include a copy of the Birth Certificate of the insured.

II. SOCIAL SECURITY NUMBER CORRECTION

Fill in the name of the insured with the change and the incorrect and correct social security number. Include copy of the Social Security card.

III. SECTION CHANGE

Indicate the current section and the one which the insured will be transferred to.

IV. COVERAGE CHANGE

Select this option if the change will be in addition or cancellation of the coverage, and fill in the information required. These changes can be only made during periods authorized in your policy. Mandatory coverage chosen by the group applies for direct optional dependents.

- Basic Coverage * — A (ambulatory)/ H (hospital)/ MQ (medical surgical)
- Dental — D
- Pharmacy — F
- Major Medical — MM/ GM
- Care Plus — C (Supplemental, Medicare Part B is required)

*In most policies, the basic coverage is mandatory. Consult your policy.

V. ADD DEPENDENT (S) OR CHANGES TO DEPENDENT INFORMATION

Select which type of dependent you are going to add. Your insurance policy has some disposition you must observe to ensure the proper processing. Fill out all spaces and include the certificates or documents indicated for each case.

- Marriage – Marriage Certificate
- Birth – Birth Certificate
- Student Children – Refer to your policy to determine age limit and include a certification from an accredited college or university
- Disabled Children – Medical Certificate Psychological or Psychiatric Evaluation
- Custodial or adopted children – Custody Award (Affidavit will not be considered)
- Additions to Care Plus coverage – Copy of the Medicare letter or the Medicare identification card

VI. CANCELLATION

Select if the cancellation is for the Main Holder or Dependents(s). The cancellations will be effective on the following month of the receipt of the cancellation request. Other cancellations will be effective as established in your policy. Complete the required blanks and include the necessary documentation for each case.

- Divorce – Judicial Decree
- Death – Death Certificate
- Marriage – Applies only for dependents

VII. CONVERTION

If the person ends coverage and will like to continue using the benefits thru an individual policy, please give him a copy of this Form (Request of Change)

VIII. ID DUPLICATE

Fill in the name and contract number from the insured to receive the id duplicate.

IX. OTHERS