BlueCross BlueShield of Alabama

GROUP CHANGE FORM

Please identify any changes to your group name, address or group contact names.

Group Name:	Division(s): ○ ALL ○ List:
Group Numbers:	Employer Identification Numbers:

GROUP NAME AND ADDRESS CHANGE

NEW GROUP NAME	**NEW GROUP EMPLOYER IDENTIFICATION NUMBER**

NEW PHYSICAL ADDRESS *(Street Address Required)*

Address 1:		
Address 1:		
City	State	Zip Code

NEW BILLING ADDRESS *(Street Address Required)*

Address 1:		
Address 1:		
City	State	Zip Code

NEW DECISION MAKER ADDRESS *(Street Address Required)*

Address 1:		
Address 1:		
City	State	Zip Code

NEW BENEFITS ADDRESS *(Street Address Required)*

Address 1:		
Address 1:		
City	State	Zip Code

GROUP CONTACT CHANGES

○ **Decision Maker** makes decisions about the company's group benefits and is authorized to contractually sign binding documents such as Enrollment Agreements, Benefit Change Forms and Administrative Service Agreements. Annual renewal letters are mailed to this contact.

New Decison Maker Contact Name:		
Title	E-Mail Address	
Phone	Extension	Fax
Name of Contact Replacing		

○ **Billing** responsible for reviewing andpaying the group's invoice. Group billing statements and invoices are mailed to this contact.

New Billing Contact Name:		
Title:	E-Mail Address:	
Phone:	Extension:	Fax:
Name of Contact Replacing:		

ADDITIONAL GROUP CONTACT CHANGES

◯ **Benefits** deals on a day-to-day basis with the company's group benefits on matters such as eligibility, benefits, claims and ERISA. Benefit booklets and letters about benefits or administrative changes are mailed to this contact.	New Benefit Contact Name:		Title:
	E-Mail Address:		
	Phone:	Extension:	Fax:
	Name of Contact Replacing:		

◯ **ADDITIONAL CONTACT** **Division(s)**	New Contact Name:		Title:
◯ **All**	E-Mail Address:		
◯ **Lists:**	Phone:	Extension:	Fax:
	Name of Contact Replacing:		

◯ **ADDITIONAL CONTACT** **Division(s)**	New Contact Name:		Title:
◯ **All**	E-Mail Address:		
◯ **Lists:**	Phone:	Extension:	Fax:
	Name of Contact Replacing:		

◯ **ADDITIONAL CONTACT** **Division(s)**	New Contact Name:		Title:
◯ **All**	E-Mail Address:		
◯ **Lists:**	Phone:	Extension:	Fax:
	Name of Contact Replacing:		

***Note: Self-funded groups making changes to Designated Plan Sponsor Employees or Third Party Administrators for the purposes of HIPAA Privacy must submit those changes on a PHI authorization form signed by the group Decision Maker.*

	PRINT NAME/eSignature	
AUTHORIZED SIGNATURE	JOB TITLE	DATE

Sign this form and return to:

Blue Cross and Blue Shield of Alabama
Attn: Underwriting
450 Riverchase Parkway East
Birmingham, AL 35244-2858

Email: GroupControlUpdates@bcbsal.org **Fax Number:** 1-205-220-5798

FOR INTERNAL USE ONLY

Underwriting ______________________
(Initials/Date)

Customer Accounts ______________________
(Initials/Date)