



Authorized Plan Contacts

Group Name: _____

Account _____

Number: _____

Who at the group should receive correspondence?

- Group Leader/Group Health Plan Primary Contact Head of Firm Other

If other is selected, please indicate who should receive correspondence:

Head of Firm:

Same as Group Leader Contact

If change, reason for change: _____

Name: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Group Leader/Group Health Plan Primary Contact:

If change, reason for change: _____

Name: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Billing Contact:

Same as Group Leader Contact

If change, reason for change: _____

Name: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Enrollment/Eligibility Contact:

Same as Group Leader Contact

If change, reason for change: _____

Name: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Agency/General Agency:

Same as Group Leader Contact

If change, reason for change: _____

Agent Name: _____

Agency: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please only allow access for the following Account/Sub Account numbers: _____

Changes to Authorized Plan Contacts
(include additions, deletions and updates only.)

Additional Plan Contact:

If change, reason for change: _____

Agent Name: _____

Agency: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Additional Plan Contact:

If change, reason for change: _____

Agent Name: _____

Agency: _____

Change Effective Date: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Additional Plan Contact:

If change, reason for change: _____

Agent Name: _____

Agency: _____

Change Effective _____

Title: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Access to BluesEnroll? Yes No

Please allow access for the following Account/Sub Account numbers: _____

Current List of Authorized Plan Contacts

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____

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Should this person still be authorized? Yes No As of date: _____

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Should this person still be authorized? Yes No As of date: _____

Name: _____

Title: _____

Should this person still be authorized? Yes No As of date: _____