

group information update form

The employer group is responsible for notifying Blue Shield of any changes to its contact information below. Please complete this form and mail it to Blue Shield of California at P.O. Box 3008, Lodi, CA 95241; or fax to **(209) 367-6603**, Attn: Group Maintenance or by email to lodiiiGDE@blueshield.ca.com. (Click on this hyperlinked email address to send.)

Please do not use this form for eligibility additions, changes, or terminations.

Group information

Please indicate your group information. (* = required fields)

*Group name:	*Group customer/policy number(s):
*Group phone:	*Group fax:

Group address information to be updated

- ☐ Updating physical address
☐ Updating billing address

New address:

City:	State:	ZIP code:
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Group contact information to be updated

- ☐ Updating the plan administrator or group contact
☐ Updating the billing contact

Name:	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Additional contact
Email:	
Name:	<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Additional contact
Email:	

Authorization information

Please provide the name of the person authorizing this update. Please note that the person signing must be an existing authorized group contact on file with Blue Shield.

*Signature of authorized group contact	*Date
*Printed name of authorized group contact	