Option Change Form

Group Name Unified School District No. 417

Group Number 07478

Effective dates **May 1, 2017** **to** **April 30, 2018**

PRODUCT **BCBS Group Health Insurance**

COMPLETE ALL INFORMATION BELOW:

Employee Name (print) _____ BCBSKS ID# or SSN _____

ELECTION

Complete this section only if you are making a change in the deductible amount. You may lower your deductible by one level (3 to 2, 2 to 1). You may raise your deductible by one or two levels (1 to 2, 1 to 3, 2 to 3).

- ❑ **Option 1 $500** _____
- ❑ **Option 2 $1,000** _____
- ❑ **Option 3 $1,500** _____

Employee Signature _____ Date _____