

**PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE OTHER SIDE OF THIS APPLICATION.**

**THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM), BLUE CARE NETWORK OF MICHIGAN (BCN) OR BCBSM BLUE CHOICE POINT OF SERVICE (POS).**

I am applying for coverage for myself and my family members identified on this application under my group or association's contract with BCBSM/BCN. Coverage begins on the date determined by BCBSM/BCN. When BCBSM/BCN accepts my application, I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility:** I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM/BCN.

**Authorization:** I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone covered under the policy. I authorize BCBSM/BCN, and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM/BCN, and for other purposes necessary for BCBSM/BCN to fulfill its contractual and statutory obligations.

**Release of information:** BCBSM does not require your Social Security Number; however, your group or association, Medicare, Medicaid and others do require it. BCN requires the Social Security Number of each subscriber. In applying for coverage, we agree to permit providers and others to release protected health information to BCBSM for purposes of administering our coverage. Upon your request, BCBSM/BCN will tell you where the information was sent.

**COBRA:** You will not be eligible for a waiver of any preexisting exclusion in BCBSM non-group coverage if you do not elect and exhaust any COBRA coverage available to you.

**BLUE CARE NETWORK ONLY**

I and my enrolled family members agree that all of our medical services must be performed, prescribed, directed or authorized by our designated BCN Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency when the time needed to contact our Primary Care Physician may mean permanent damage to our health. Unauthorized services that are not an immediate emergency, as described above, received from non-Blue Care Network providers will not be covered.

The BCN service area excludes Branch, Lake, Lenawee, Mason, Missaukee, Osceola and Sanilac counties. Residents of these counties may receive services in a BCN covered county by providing BCN with an Out of Area Waiver at the time of enrollment.

I agree to assign to BCN my entire right of recovery of the cost of hospital, medical and prescription services delivered by or paid for by BCN against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts whether by redemption award or voluntary payment or otherwise.

I authorize any holder of medical or other information, about me or my enrolled family members, to release to the centers for Medicare and Medicaid services, any insurance company, or any HMO and their agents any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to Blue Care Network on my behalf for any services furnished to me and my enrolled family members by Blue Care Network.

**BLUE CHOICE POINT OF SERVICE ONLY**

I and my enrolled family members agree that all our medical services must be performed, prescribed, directed or authorized by our designated POS Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency and the time needed to contact our Primary Care Physician(s) may mean permanent damage to our health. Unauthorized services that are not an immediate and unforeseen emergency, as described above, will be subject to applicable out of network deductibles and copays.

Send completed form to:  
Blue Cross Blue Shield of Michigan  
Membership and Billing - 1704  
P.O. Box 2260  
Detroit, MI 48231-2260

Blue Care Network of Michigan  
25925 Telegraph Road  
Membership and Billing - B811  
Southfield, MI 48086-5043

POS/Blue Choice Point of Service Center  
P.O. Box 5097  
Southfield, MI 48086-5097

**INSTRUCTIONS FOR COMPLETING ENROLLMENT/CHANGE OF STATUS FORM  
ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED**

**SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-4:**

- SECTION 1:** Enter subscriber information including: social security or assigned contract number, last name, first name, middle initial, complete home address, marital status, sex, date of birth, evening and day phone numbers.
- SECTION 2:** List all persons that you wish to add or delete. ATTACH ADDITIONAL ENROLLMENT FORMS IF NECESSARY TO ADD MORE DEPENDENTS. Include sex, birthdate, social security number and relationship code. Required documentation must be attached to the Enrollment/Change of Status Form. For BCN or POS, using the appropriate paper or web based directory, select the name of a BCN/POS participating primary care physician (PCP) for each person listed. In addition, include physician code - (if known), physician location (street, city) and whether or not seen by the physician within the last 12 months. Indicate, by checking appropriate box, if you have been previously enrolled in BCBSM, BCN or POS. Indicate the contract number under which you were covered. Complete alternate address, if applicable. If changing a PCP, check the PCP change box in Section 5 and include the information listed above for each member changing a PCP and indicate reason for requesting the change. This form does not need to be signed by the group representative for PCP change. If member is requesting a change in PCP only, that can also be done on the internet at [www.bcbsm.com](http://www.bcbsm.com) or by calling Customer Service.
- SECTION 3:** If any person listed in Section 2 has other medical insurance coverage either through a group or on an individual basis, please check the "Yes" box. Indicate person covered, group name, policy number, insurance carrier name and location. If you or any person listed in Section 2 is enrolled in Medicare, please check the "Yes" box. **If Yes, attach a copy of the Medicare card(s).** Check applicable box for which Medicare recipient qualifies for Medicare Coverage. POS is not available to Medicare enrollees. If Medicare coverage applies, enrollment will not be processed without a copy of Medicare card(s).
- SECTION 4:** You must sign the form and indicate date form is completed.

**GROUP IS REQUIRED TO COMPLETE SECTION 5** (This form cannot be processed for enrollment purposes without completion of the following):

- Coverage Plan for BCN:** Please provide group I.D., subgroup I.D. and class I.D., if available. Include group name, representative, signature and date. Indicate the products included, i.e., medical, prescription drugs, hearing, vision, or dental. Check product box. Note: If enrolling in BCN and there is a separate group number for your BCBSM dental or vision product, complete two Enrollment Change of Status forms - one with BCBSM Dental/Vision group/suffix number and one with the BCN group, sub group and class I.D. and submit to the appropriate areas.
- Coverage Plan For BCBSM:** Indicate which products you are selecting. Please provide group name, signature and date. If available, complete BCBSM group number/suffix (8 digits), service code, and badge number or employee I.D. if applicable.
- Enrollment:** Indicate BCBSM/BCN effective date and subscriber's actual hire/rehire or part time to full time status date. Check all applicable enrollment boxes. Health Insurance Portability and Accountability ACT (HIPAA) mandates that groups provide special open enrollment periods for their subscribers. These special enrollment periods include enrollment or changes as the result of marriage, birth, adoption, or placement of adoption, loss of eligibility or termination of group contributions.
- Reason For Change:** To change a subscriber/dependent(s) health care coverage, indicate BCBSM/BCN effective date. Please check the reason for change or indicate HIPAA qualifying event if it is not listed.
- COBRA Enrollment:** To enroll terminating member(s) for COBRA health care coverage, please enter the original COBRA qualifying status date. Also please check the original COBRA qualifying event.
- MEDICARE STATUS:** Indicate primary coverage per Federal Medicare Secondary Payor (MSP) law(s) and attach copy of Medicare card(s).

**PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT**



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

# ENROLLMENT/ CHANGE OF STATUS

## SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4

Subscriber Social Security		Subscriber Last Name <input type="checkbox"/> check if new			Subscriber First Name			MI
Home Street Address <input type="checkbox"/> check if new				City		State	Area Code/Home Phone	
Zip Code		County		Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Sex	Date of Birth	Area Code/Work Phone

SECTION 1

SUBSCRIBER SECTION 2

List all persons to be enrolled / terminated:							PRIMARY CARE PHYSICIAN NAME - BCN/POS ONLY				Seen in the last 12 months			
	Circle One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MMDDYYYY	SOCIAL SECURITY #	* CODE	LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION	YES	NO
Subscriber	Add Delete													
Spouse	Add Delete													
Dep-1	Add Delete													
Dep-2	Add Delete													
Dep-3	Add Delete													

* Relationship Code					Previous BCBSM/POS Affiliation			PCP Change Reason - BCN/POS ONLY			
<b>N</b> - Child (by Birth or Adoption) <b>P</b> - Principal Support* <b>SD</b> - Sponsored Dependent* <b>S</b> - Stepchild <b>A</b> - Child Adoption in Process** <b>C</b> - Court Order Coverage (QMCSO)** <b>F</b> - Family Continuation 19+ <b>L</b> - Legal Guardianship** <b>D</b> - Disabled Child (PA 275)***					I have previously been enrolled in : (Check applicable box) <input type="checkbox"/> BCBSM <input type="checkbox"/> BCN <input type="checkbox"/> POS			Enter contract # _____			
* = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement											

If the permanent address of the spouse or dependent is different from address in section one, please complete information below:

Spouse/Dependent (Full name)		Street Address			City	State	Zip code
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OTHER COVERAGE SECTION 3

Do you, your spouse or dependent(s) maintain other health coverage?  NO  YES If Yes, complete below:

Person covered (Full name)	Group	Policy Number	Carrier	Location
Person covered (Full name)	Group	Policy Number	Carrier	Location

SIGNATURE SECTION 4

Are you, your spouse or any dependents listed in section 2 enrolled in Medicare ?  No  Yes If Yes, attach a copy of Medicare card(s).  Actively working  Retired  Under 65  ESRD (End Stage Renal Disease)

**I have read and understand the conditions on the reverse side of this form.**

Subscriber Signature	Signature Date	Remarks
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GROUP USE ONLY SECTION 5

**GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES**

BCBSM Group/Suffix or BCN Group I.D. / Subgroup I.D.	BCBSM Service Code/BCN Class I.D.	Employee I.D. Badge #	Group Name	Group Representative Signature	Date
<b>COVERAGE/PLAN:</b> Blue Care Network Plan: <input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental			<b>BCBSM Coverage:</b> <input type="checkbox"/> Traditional/CMM <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> Dental Only <input type="checkbox"/> Vision Only		
<b>ENROLLMENT:</b>	Effective Date:	Date of Hire or Full Time Status:	<input type="checkbox"/> New <input type="checkbox"/> Part-Time <input type="checkbox"/> Hourly <input type="checkbox"/> Retiree <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Return to work from Layoff <input type="checkbox"/> Rehire <input type="checkbox"/> Full-Time <input type="checkbox"/> Salary <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____		
<b>REASON FOR CHANGE:</b>	Effective Date:	<input type="checkbox"/> Marriage <input type="checkbox"/> Duplicate ID Card <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Loss of Coverage (Certificate of Creditable Coverage Required) <input type="checkbox"/> PCP Change <input type="checkbox"/> FCR/DCCR <input type="checkbox"/> Transfer <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____			
<b>CANCEL COVERAGE:</b>	Last Date of Coverage:	<b>REASON:</b> <input type="checkbox"/> Contract <input type="checkbox"/> COBRA <input type="checkbox"/> Dependent Over Age <input type="checkbox"/> Left Employment <input type="checkbox"/> Spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ <input type="checkbox"/> Dependent(s) list in Section 2 <input type="checkbox"/> Retired <input type="checkbox"/> Other Insurance			
<b>COBRA ENROLLMENT:</b>	Original Qualifying Date:	<input type="checkbox"/> Termination <input type="checkbox"/> Layoff <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Previous Contract # _____ <input type="checkbox"/> Reduction of Hours <input type="checkbox"/> Deceased Subscriber <input type="checkbox"/> Loss of Dependent Status			
<b>MEDICARE STATUS:</b>	Effective Date:	<input type="checkbox"/> Medicare Primary per MSP Law(s) <input type="checkbox"/> BCBSM/BCN Primary per MSP Law(s) <b>Please attach a copy of Medicare card(s)</b>			