

ENROLLMENT / CHANGE OF STATUS



Subscriber SSN (or assigned contract number) - - BCBSM Group - Suffix BCN Group ID Subgroup ID Class ID

SUBSCRIBER INFORMATION

Subscriber Last Name check if new Subscriber First Name M.I. Marital Status S M M F Gender M F Subscriber Birth Date / / Home Phone - - check if new

Home Street Address check if new City State Zip Code Work Phone - - check if new

County Country - if other than USA Email - optional

List all persons to be enrolled / terminated:

	CHECK ONE	LAST NAME	FIRST NAME	M	I	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	* REL CODE
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-1	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-2	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-3	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		

BCN/POS - PRIMARY CARE PHYSICIAN (PCP)

	PHYSICIAN LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION	Seen in the last 12 months?	* Relationship Code
Subscriber					<input type="checkbox"/> Yes	N - Child (by Birth or Adoption) A - Child Adoption in Process** S - Stepchild L - Legal Guardianship** F - Family Continuation 19+ SD - Sponsored Dependent* P - Principal Support* C - Court Order Coverage (QMCSO)** D - Disabled Child (BCBSM - PA350) (BCN - PA218)*** * = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement
Spouse					<input type="checkbox"/> Yes	
Dep-1					<input type="checkbox"/> Yes	
Dep-2					<input type="checkbox"/> Yes	
Dep-3					<input type="checkbox"/> Yes	

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

Spouse/Dependent (Full Name) Street Address City State Zip code

Do you, your spouse or dependent(s) maintain other health coverage? NO YES If Yes, complete below: Check here if this applies to all members on the contract:

Person covered (Full Name)	Group Name	Policy Number	Carrier	Location
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Are you, your spouse or any dependent(s) listed 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 page 1 of this form.

Subscriber Signature Signature Date Remarks

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

Page 2 – Subscriber Information

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Subscriber Last Name (check box if new), Subscriber First Name, and Middle Initial. If there is not enough spaces to accommodate your full name, print or type full name in the remarks section at the bottom of page 3. Indicate whether single or married, male or female.
- Enter Subscriber date of birth, home phone number (check box if new).
- Enter home address beginning with street address (check box if new), City, State & Zip Code. Enter work phone number (check box if new).
- Enter county name for home address, Country name (if other than USA), email address.
- List all persons to be enrolled/terminated: Enter name(s) on appropriate line – spouse, dependent 1, 2, and 3 as applicable. Complete additional forms if more dependents are to be covered. Check if they are to be added or deleted. Enter last name, first name, middle initial, male or female, date of birth, social security number and rel code (relationship codes are listed below).
- BCN/POS Only - Enter physician last name, first initial, physician number and location for each member (subscriber, spouse, dependent 1, 2, and 3). Check the box if the member has been seen by the designated physician within the last 12 months.
- BCN/POS Only - PCP Change Reason – enter reason for request to change primary care physician. Group representative signature not required. Change can also be made at MiBCN.com., if BCN.
- Previous BCBSM Affiliation – check if previously enrolled in either BCBSM or BCN and enter contract number.
- Permanent Address – Enter the spouse/dependents address if different from the address indicated above.
- Other Health Coverage - Indicate no or yes if you, your spouse or dependent maintain other health care coverage – if yes, complete name of person covered, group name, policy number, carrier name and location. If other health coverage applies to all members on the contract, check the applicable box.
- Indicate if you, your spouse or dependent are enrolled in Medicare – if yes, a copy of your Medicare card(s) is required, check off applicable status: actively working, retired, under 65 or ESRD (End Stage Renal Disease).
- In the signature section, sign your full name, enter the date you signed the form and make any notations in the remarks field.

Page 3 – Group Use only – check and complete appropriate boxes

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Group name and employee Identification Badge number, if applicable.
- BCBSM Only: Enter BCBSM Service Code (12 digit), Group Representative Signature and date.
- Indicate if subscriber is enrolling in either BCBSM or Blue Care Network, check all applicable coverage the subscriber is enrolling in even coverage they wish to maintain – medical, dental, vision. 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, subgroup and class I.D. and submit to the appropriate areas (see bottom on page 1).
- **NEW** Section: check applicable box, enter date of hire, effective date, average number of hours worked per week and job title.
- **CHANGE** section: to change a subscriber/dependent(s) health care coverage check the appropriate box, enter date of event and effective date.
- **CANCEL** Section: check applicable box for contract holder, spouse or dependent, check reason for canceling and enter last date of coverage.
- **COBRA** Section: check reason, enter previous contract number and enter the original qualifying status date.
- **TRANSFER/LOSS OF COVERAGE** Section: if you checked transfer in the new section above, or loss of coverage in the change section above, indicate the carrier's name, contract holder name, policy number and termination date.
- **MEDICARE STATUS** Section: indicate if Medicare is primary or BCBSM/BCN is primary per MSP (Mandatory Secondary Payer) law(s), enter effective date of the Medicare coverage and attach a copy of the Medicare card(s).
- **BLUE HEALTHCARE BANK OPTIONS** Section: indicate if Blue Healthcare Bank is being added, changed or canceled. Enter the effective date, check off applicable options. If any of the FSA options are selected also enter the goal amount. If additional options are offered, write the option(s) in the Blue Healthcare Bank options area.

PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT