Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status

☐ BCBSM ☐ BCN Member (see instructions on Page 7)

BCBSM group / Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date
–					/ /

Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status*	Gender
				☐ S ☐ M	☐ M ☐ F

New home street address*	City*	State*	ZIP code*	E-mail*

County*	Country – if other than USA*	New primary phone* ☐ Home ☐ Work ☐ Cell	New secondary phone* ☐ Home ☐ Work ☐ Cell	* Indicate changes only	Relationship code (See instructions for codes)

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)	Relationship code (See instructions for codes)
Spouse ☐Add ☐Delete				☐ M ☐ F	/ /		
Dep. 1 ☐Add ☐Delete				☐ M ☐ F	/ /		
Dep. 2 ☐Add ☐Delete				☐ M ☐ F	/ /		
Dep. 3 ☐Add ☐Delete				☐ M ☐ F	/ /		
Dep. 4 ☐Add ☐Delete				☐ M ☐ F	/ /		

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents maintain other health coverage? ☐ Yes ☐ No If yes, complete below: ☐ Check here if this applies to all members on the contract.

Person covered (full name)	Group name	Policy number	Carrier	Address

I have read and understand the conditions of this form. Subscriber signature: Date: / /

Health savings and flexible spending account options

☐ FSAMED Effective date: / / Goal amount: ☐ HSA

☐ FSADEPCA Effective date: / / Goal amount: ☐ HSA opt out

Product indicator code ☐ Add ☐ Change ☐ Cancel

Employer/Group use only

Group name	Employe I.D. badge or department #	Benefit code	Plan code

Check reason for change below:

☐ Marriage ☐ Loss of eligibility (prior coverage)

☐ Dependents ☐ Name change ☐ Open enrollment

Date of event: / / Effective date: / /

Check type of cancellation and reason below. Type: ☐ Contract ☐ Spouse ☐ Dependents

Reason: ☐ COBRA ☐ Death ☐ Left employment

☐ Divorce ☐ Dependent over age ☐ Other

☐ Retired ☐ Other insurance

Last date of coverage: / /

Loss of eligibility (prior coverage)? ☐ Yes ☐ No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date
			/ /

Are any listed members enrolled in Medicare? ☐ No ☐ Yes If Yes, check category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD

☐ Medicare primary per MSP laws

☐ BCBSM or BCN primary per MSP laws

Medicare A effective date: / / Medicare B effective date: / / Medicare D effective date: / / HIC #:

Instructions for completing *Change of Status* form on Page 6

- Indicate if enrolling in BCBSM or BCN. if BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 if you're changing your PCP.
- Enter BCBSM group and division number (suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the *Employer signature* section.

Subscriber information:

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name, and middle initial. Enter the marital status, if changing. Indicate if you are a male or female.
- Enter new home address beginning with street address, city, state and ZIP code. Enter your new e-mail address, if changing.
- Enter new county name for home address and country name (if other than USA). Enter new primary phone, if changing, and indicate if home, work or cell. Enter new secondary phone number and indicate if home, work or cell.
- List all persons to be added or deleted. Enter name(s) on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if all your dependents do not fit on this form.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

N - Child (by birth or adoption)	A - Child adoption in process **	C - Court order coverage (QMCSO) **
S - Stepchild	L - Legal guardianship **	D - Disabled child ***
P - Principal support (BCN only)*	SD - Sponsored dependent *	M - Medicare

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate Yes or No if you, your spouse or dependent maintain other health care coverage. If Yes, list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings and flexible spending account options:

- Check all applicable options and enter the goal amount. Enter the four digit product indicator code.

FSAMED – Medical spending account	HSA – Health Savings Account
FSADEPCA – Dependent care flexible spending account	HSA – Health Savings Account opt out

Employer/Group use only:

- Enter employer or group name, and employee identification, badge or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (BCBSM plan servicing this contract). Enter date of hire and effective date.
- Indicate the reason for change. Check the applicable box.
- Check the appropriate type of cancellation and reason. For BCN only, complete this *Change of Status* form (Page 6) to cancel active coverage, and complete the *New Subscriber Enrollment* form (Page 2) to enroll in COBRA.
- For loss of eligibility (prior coverage), indicate Yes or No. If Yes, please indicate the carrier name, contract holder name, policy number and termination date.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary per mandatory secondary payer laws, and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation required for enrollment.