Blue Cross Blue Shield Blue Care Network of Michigan

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

SUBSCRIBER NEW ENROLLMENT

(see Page 3 for instructions) ☐ BCBSM ☐ BCN Member - Complete Page 4 for PCP Selection

BCBSM group number | Division | BCN group ID | Subgroup ID | Class ID | Employer representative signature | Date

Subscriber information

Social Security number (Required) | Subscriber last name | Subscriber first name | M.I. | Marital Status ☐ S ☐ M | Gender ☐ M ☐ F | Subscriber birth date

Home street address | City | State | ZIP Code

County | Country - if other than USA | ☐ Home ☐ Work ☐ Cell Primary phone | ☐ Home ☐ Work ☐ Cell Secondary phone

E-mail - optional

List all persons to covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*Relationship code (see instructions for codes)
Spouse				☐ M ☐ F	/ /		
Dep. 1				☐ M ☐ F	/ /		
Dep. 2				☐ M ☐ F	/ /		
Dep. 3				☐ M ☐ F	/ /		
Dep. 4				☐ M ☐ F	/ /		

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

Spouse or dependent (full name) | Street address | City | State | ZIP code

Coordination of benefits information

Do you, your spouse or dependent(s) 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)	Employer or 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

☐ HSA ☐ HSA Opt out Product indictor code: ☐ FSAMED Goal amount: ☐ FSADEPCA Goal amount:

Employer/Group use only

Group name: | Employee ID badge #:

Benefit code: | Plan code: | Date of hire: / / | Effective date: / /

Check coverage if applicable : ☐ Medical ☐ Dental ☐ Vision

Check type of enrollment: ☐ New ☐ Rehire ☐ Full time ☐ Part time ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Retiree ☐ Hourly ☐ Salary ☐ Surviving spouse ☐ Open enrollment

Average hours worked per week (required): _____

Job title (required): _____

COBRA enrollment Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Loss of dependent status ☐ Deceased subscriber

Previous contract # | Original qualifying date / /

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

Carrier's name (Including BCBSM and BCN): | Contract holder name | Policy# | Termination date: / /

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD HIC#:

☐ Medicare primary ☐ BCBSM or BCN primary

Medicare A effective date / / | Medicare B effective date / / | Medicare Part D effective date / /

1385617854

Instructions for completing *Subscriber New Enrollment* form on Page 2

- Indicate if enrolling in BCBSM or BCN: If enrolling with BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 to designate your primary care physician.
- Enter BCBSM group and division number (for example, 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. Indicate whether single or married, male or female. Enter subscriber date of birth.
- Enter home address beginning with street address, city, state and ZIP code. Enter e-mail address.
- Enter county name for home address, country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if you have more than four dependents.
- 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.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrollment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA check the reason for COBRA. Indicate the previous contract number and the original qualifying date.
- 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 for enrollment.