



Blue Cross  
Blue Shield  
Blue Care Network  
of Michigan

**SUBSCRIBER INFORMATION - COMPLETE SECTIONS 1 THROUGH 4**

Subscriber Social Security  **XXXX** Subscriber Last Name  **check if new** Subscriber First Name \_\_\_\_\_ MI \_\_\_\_\_

Home Street Address  **check if new** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ County \_\_\_\_\_

Area Code/Evening Phone \_\_\_\_\_ Area Code/Day Phone \_\_\_\_\_

Current Marital Status  Single  Married

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

**ENROLLMENT/  
CHANGE OF STATUS**

**SUBSCRIBER SECTION 2**

List all persons to be enrolled / terminated:

RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.	PREVIOUS CARE PHYSICIAN NAME	BCSSM/BCN POS ONLY	PCP CHANGE REASON	BCN/POS ONLY
ADD/DELETE	MM/DD	XXXX-XX-XXXX	LAST NAME FIRST INITIAL	PHYSICIAN CODE	PHYSICIAN LOCATION	PHYSICIAN LOCATION
Dep-1	ADD					
Dep-2	ADD					
Dep-3	ADD					

Relationship Code \_\_\_\_\_

Previous BCSSM/BCN/POS Attitutor: \_\_\_\_\_

PCP Change Reason: \_\_\_\_\_

BCN/POS ONLY

**OTHER COVERAGE SECTION 3**

Do you, your spouse or dependent(s) maintain other health coverage?

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

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

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

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

Have read and understand the conditions on the reverse side of this form: \_\_\_\_\_ Date \_\_\_\_\_

Subscriber Signature \_\_\_\_\_

**SECTION 4**

Group Number / Suffix (8 digits) \_\_\_\_\_ Service Code \_\_\_\_\_

Group Name \_\_\_\_\_

Group Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

**PP01**

GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES:

BCSSM:  Traditional/CAIM  POS  PPO  Dental Only  Vision Only  BCN Region:  East  West  Mid  Southeast

ENROLLMENT: Effective Date: \_\_\_\_\_ Date of Hire or Full Time Status: \_\_\_\_\_

REASON FOR CHANGE: Effective Date: \_\_\_\_\_

TERMINATION: Last Date of Coverage: \_\_\_\_\_

COBRA QUALIFYING STATUS: Original Qualifying Date: \_\_\_\_\_

MEDICARE STATUS: Effective Date: \_\_\_\_\_

**SECTION 5**

REASON FOR CHANGE:  Marriage  Duplicate ID Card  Contract  Divorce  Death  Other \_\_\_\_\_

Dependents  Loss of Coverage (Certificate of Creditable Coverage Required)  HIPAA Qualifying Event (describe event): \_\_\_\_\_

FCR/DCCR  Transfer to Division/Suffix  Name Change (new name): \_\_\_\_\_

REASON:  Rollover  Retired  Dependent Over Age  Other \_\_\_\_\_

Termination  Layoff  Divorced/Legal Separation  Previous Contract # \_\_\_\_\_

Reduction of Hours  Deceased Subscriber  Loss of Dependent Status

Medicare Primary  BCSSM/BCN Primary

**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 enroll or terminate. 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 or a current patient. 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 changes. If member is requesting a change in PCP only, that can also be done by calling Customer Service or on the internet at [www.bcbsm.com](http://www.bcbsm.com).

**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 has Medicare coverage, please check the "Yes" box. If Yes, attach a copy of the Medicare card(s). Check applicable box under 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.

**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):

Please provide group name, signature and date. If available, complete group number/suffix (8 digits), service code, and badge number if applicable.

**Product** 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 and suffix number and one with the BCN group and suffix number and submit to the appropriate areas.

**Enrollment:** Indicate BCBSM/BCN effective date and subscriber's actual hire/rahire 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 off the reason for change or indicate HIPAA qualifying event if it is not listed.

**COBRA Qualifying Status:** To enroll terminating members as subscriber and/or dependent(s) for COBRA health care coverage, please enter the original COBRA qualifying status date. Also please check off the original COBRA qualifying event.

**MEDICARE STATUS:** Indicate primary coverage.

**PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT**