

New Subscriber Enrollment, BCN Primary Care Physician Selection or Change of Status Form

Please read the following information before completing the attached New Subscriber Enrollment, BCN-Primary Care Physician Selection or Change of Status forms.

The information on this form and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for coverage for myself and my family members identified on this application under my employer's or association's contract with BCBSM or BCN. Coverage begins on the date determined by BCBSM or BCN. When BCBSM or 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 or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. It may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my employer or association of changes in my status 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 or BCN 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 or BCN and for other purposes necessary for BCBSM or BCN to fulfill its contractual and statutory obligations.

Release of information: I acknowledge that BCBSM or BCN requires me to provide my Social Security number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM or BCN for purposes of administering our coverage. Upon my request, BCBSM or BCN will tell me where the information was sent.

COBRA: I will not be eligible for a waiver of any preexisting exclusion in BCBSM non-employer coverage if I do not elect and exhaust any COBRA coverage available to me. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize BCBSM or BCN to provide claims information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

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 physicians except in the case of an immediate and unforeseen medical emergency when the time needed to contact our PCPs may mean permanent damage to our health. Unauthorized services that are not an emergency, as described above, received from non-BCN 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 nonemergent services in a BCN-covered county.

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 BCN on my behalf for any services furnished to me and my enrolled family members by BCN.

Send completed forms to:

For Blue Cross Blue Shield of Michigan
Membership and Billing - M.C. 1704
Blue Cross Blue Shield of Michigan
P.O. Box 2260
Detroit, MI 48231-2260
Fax: 866-900-2619 or
866-900-2829

For Blue Care Network
Membership and Billing - M.C. C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086
Fax: 877-218-1466



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SUBSCRIBER NEW ENROLLMENT

(see Page 3 for instructions)

BCBSM BCN Member - Complete Page 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 M F Gender S M 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				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 1				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 2				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 3				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 4				<input type="checkbox"/> M <input type="checkbox"/> 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: / /

Flexible spending account arrangements

FSAMED Goal amount: FSADEPCA Goal amount: FSAPARK Goal amount: FSATRANS Goal amount:

Employer/Group use only

Group name:	Employee ID badge #:
Benefit code:	Plan code:
Date of hire:	Effective date:
/ /	/ /

Check coverage if applicable (BCBSM only): Dental only Vision only Dental and vision only Other

Check type <input type="checkbox"/> New <input type="checkbox"/> Transfer <input type="checkbox"/> Hourly <input type="checkbox"/> Full time <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Part time <input type="checkbox"/> Retiree	of enrollment: <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff <input type="checkbox"/> Salary <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Open enrollment	Average hours worked per week (required): <input type="text"/>	Job title (required): <input type="text"/>	COBRA enrollment <input type="checkbox"/> Termination <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Divorce or legal separation	Check reason: <input type="checkbox"/> Layoff <input type="checkbox"/> Loss of dependent status <input type="checkbox"/> Deceased subscriber
		Previous contract # <input type="text"/>	Original qualifying date <input type="text"/> / <input type="text"/> / <input type="text"/>		

Loss of 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#:

<input type="checkbox"/> Medicare primary	Medicare A effective date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare B effective date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part D effective date <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="checkbox"/> BCBSM or BCN primary			

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Instructions for completing *New Subscriber 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 PCP.
- 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 your 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)

L - Legal guardianship **

S - Stepchild

SD - Sponsored dependent *

F - Family continuation

C - Court order coverage (QMCSO) **

P - Principal support

D - Disabled child (P.A. 275) ***

A - Child adoption in process **

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.

Flexible spending account arrangements

- Check all applicable options and enter the goal amount.

Flexible spending account options:

FSAMED – Medical spending account

FSAPARK – Parking flexible spending account

FSADPCA – Dependent care flexible spending account.

FSATRANS – Transportation flexible spending account

Employer and 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.
- For BCBSM only, indicate if employee is enrolling in stand-alone coverage for dental only, vision only or dental and vision only coverage.
- Check type of enrollment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If COBRA enrollment, check the reason for COBRA. Indicate the previous contract number and the original qualifying date.
- For loss of 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 MSP (mandatory secondary payer) laws, and enter effective date of the Medicare Parts A, B and D coverage. For BCN members, please attach a copy of the Medicare card.



BCN Primary Care Physician Selection (see Page 5 for instruction)

Subscriber Social Security number (required for age 45 and older)	BCN group number	Subgroup number	Class number
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If you are enrolling in BCN, you need to select a primary care physician for you and each person on your contract. List your selection(s) on this form. You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a PCP. You also need to fill out this form if you are already enrolled in BCN and have decided to change your PCP.

Need information about available primary care physicians?

Our Web site MiBCN.com/find provides the most current information on BCN-affiliated primary care physicians. You can search for a doctor by family practice, general medicine, internal medicine, internal medicine and pediatrics, pediatrics and preventive medicine, city or hospital group.

Member Information						
	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If changing PCPs, list reason	Seen in the last 12 months?
Subscriber						<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 1						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 2						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 3						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 4						<input type="checkbox"/> Yes <input type="checkbox"/> No
Group/Employer's name:				Date you changed to this physician:		
I have read and understand the conditions of this form. Subscriber signature:				Date: / /		

Return this form to start your health care partnership

We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

Fax your completed form to 877-218-1466.

Or, mail to:

Membership and Billing

Mail Code C411

Blue Care Network

P.O. Box 5043

Southfield, MI 48086-5043

Changing your primary care physician is limited to once every 30 days. **All changes become effective two business days after we receive this form — unless you request a later effective date.** You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs.

On an exception basis only, you may request to change your PCP effective immediately by calling the Physician Selection Line at 888-656-8276. TTY users call 800-257-9980.

Instructions for completing the *BCN Primary Care Physician Selection* form on Page 4

- Enter subscriber Social Security number, BCN group number, subgroup number and class number.
- Enter each member's last and first name, physician's last name and first name, physician's INPI number, physician's address and the reason for changing your PCP, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician's NPI number when searching for a doctor on **MiBCN.com/find**.
- Enter the employer's name and the date you changed to this physician.
- In the signature section, sign your full name and enter the date that you signed the form.

Note: Submit the *BCN Primary Care Physician* form with your *New Subscriber Enrollment* form when enrolling with BCN.



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
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Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status* <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F
New home street address*		City*	State*	ZIP code*	E-mail*
County*	Country – if other than USA*	New primary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	New secondary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		* Indicate changes only

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 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 3 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> 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
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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
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I have read and understand the conditions of this form. Subscriber signature: _____ Date: _____

Flexible spending account arrangements

FSAMED Effective date: _____ Goal amount: _____ FSAPARK Effective date: _____ Goal amount: _____ Add Change Cancel

FSADEPCA Effective date: _____ Goal amount: _____ FSATRANS Effective date: _____ Goal amount: _____

Employer/Group use only

Group name	Employee I.D. badge or department #	Benefit code	Plan code
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<p>Check reason for change below:</p> <input type="checkbox"/> Marriage <input type="checkbox"/> FC/DCCR <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Dependents <input type="checkbox"/> Name change	<p>Check type of cancellation and reason below. Type: <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p> <p>Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Death <input type="checkbox"/> Left employment <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other <input type="checkbox"/> Retired <input type="checkbox"/> Other insurance</p> <p>Last date of coverage: _____</p>
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Loss of prior coverage? Yes No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date
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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 Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC #: _____

BCBSM or BCN primary per MSP laws

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)	L - Legal guardianship **
S - Stepchild	SD - Sponsored dependent *
F - Family continuation	C - Court order coverage (QMCSO) **
P - Principal support	D - Disabled child (P.A. 275) ***
A - Child adoption in process **	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.

Flexible spending account arrangements:

- Check all applicable options and enter the goal amount.

Flexible spending arrangement options:

FSAMED – Medical spending account	FSAPARK – Parking flexible spending account
FSADEPCA – Dependent care flexible spending account.	FSATRANS – Transportation flexible spending account

Employer and 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 - *Marriage, Dependents FC/DCR* (Family Continuation, Dependent Continuation Rider) *Name change* or *Loss of coverage*.
- Check the reason for the change. 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 prior loss of 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 MSP (mandatory secondary payer) laws, and enter effective date of the Medicare Parts A, B and D coverage. For BCN members, please attach a copy of the Medicare card.

Please provide all documentation required for enrollment.