Enclosed forms: ***New Subscriber Enrollment form*** **(Page 2)** ***Blue Cross Personal Choice/BCN Primary Care Physician Selection form*** **(Page 4)**
Change of Status form **(Page 6)** ***Health Savings and Flexible Spending Account Options form*** **(Page 8)**

Please read the following information before completing the attached forms. The information on these forms 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 health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for me or my dependents. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my covered dependents and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying 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 Blue Cross or BCN or my primary care physician to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not pre-empt a new-hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, I and my enrolled dependents agree to permit health care providers and others to release "protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

I and my enrolled family members agree that all our medical services may be performed, prescribed, directed or authorized by our designated BCN primary care physician except in the case of an immediate and unforeseen medical emergency when the time needed to contact our primary care physician 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.

I agree to assign to BCN the right to recover from any person or organization the cost of hospital, medical and prescription services delivered by or paid for by BCN as a result of accident or disease, including injuries or disease claimed under workers' compensation laws or acts, whether by redemption award, voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release any information needed to determine benefits coverage to the Centers for Medicare and Medicaid Services, any insurance company or any HMO and their agents. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to BCN on my behalf for any services that BCN provides to me and my enrolled family members.

Send completed forms to:

(For Blue Cross Blue Shield of Michigan)
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610G
P.O. Box 2260
Detroit, MI 48226 Fax: 1-866-900-2619 or 1-866-900-2829

(For Blue Care Network)
Blue Care Network
Membership and Billing – M.C. H300
P.O. Box 5043
Southfield, MI 48086

Fax: 1-877-218-1466

Blue Cross Blue Shield Blue Care Network of Michigan

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

Blue Cross Blue Shield Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

New Subscriber Enrollment

(see Page 3 for instructions)

☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network

(Also complete Page 4 for Personal Choice or primary care physician selection)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature

Subscriber information

Date	☐ Non U.S. citizen	Social Security/TIN 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	Primary telephone number	☐ Home ☐ Work ☐ Cell	Secondary telephone number	☐ Home ☐ Work ☐ Cell	Email

List all persons to be covered:

	Last name	First name	MI	Gender	Date of birth	Non U.S. citizen	Social Security/TIN number (required)	*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 dependents have other health care 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, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

☐ FSA ☐ HRA ☐ HSA ☐ HSA Opt out ☐ Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date

Check coverge if applicable: ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

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

Old group division/subgroup _____

New group division/subgroup _____

Average hours worked per week (required): _____

Job title (required): _____

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

Previous contract number

Original qualifying date

Loss of eligibility (prior coverage) ☐ Yes ☐ No If "Yes", complete:	Carrier's name (Including Blue Cross and BCN)	Contract holder name	Policy number	Termination date

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

☐ Medicare primary ☐ Subscriber ☐ Spouse ☐ Blue Cross or BCN primary ☐ Dependent name:	Medicare A effective date	Medicare B effective date	Medicare Part D effective date

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

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Personal Choice or with BCN, you are also required to complete the *Blue Cross Personal Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross 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:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- Enter county name for home address and 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,middle initial, male or female and date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member (see below).

Relationship codes:

N - Child (by birth or adoption)	A - Child adoption in process **	C - Court order coverage (QMCSO)**	SP - Spouse
S - Stepchild	L - Legal guardianship **	D - Disabled child***	DP - Domestic partner *
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 have 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, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. 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. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No". If "Yes", please indicate the carrier name, contract holder name, policy number an termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes", check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BCN is primary 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.

Blue Cross Blue Shield Blue Care Network of Michigan

Blue Cross Personal Choice PPO/BCN Primary Care Physician Selection (see Page 5 for instructions)

☐ Non U.S. citizen	Subscriber Social Security number/TIN (required)	Blue Cross/BCN group number	Blue Cross division/BCN subgroup number	BCN class number

If you are enrolling in Blue Cross Blue Shield of Michigan Personal Choice PPO or Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections 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 primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician.

Need information about available primary care physicians?

Our website, **bcbsm.com/find-a-doctor**, provides the most current information on Blue Cross and BCN-affiliated primary care physicians. You can search for a family practice, general medicine, internal medicine, pediatrics, 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						☐ Yes ☐ No
Spouse						☐ Yes ☐ No
Dep. 1						☐ Yes ☐ No
Dep. 2						☐ Yes ☐ No
Dep. 3						☐ Yes ☐ No
Dep. 4						☐ Yes ☐ No

Group/Employer's name:	Effective date of change:
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.

For Blue Cross Blue Shield of Michigan: Fax your complete form to 1-866-900-2619 or 1-866-900-2829
Or mail to:
Blue Cross Blue Shield of Michigan Membership and Billing - M.C. 610G
P.O. Box 2260
Detroit, MI 48226

For Blue Care Network:
Fax your complete form to 1-877-218-1466
Or mail to:
Blue Care Network
Membership and Billing - M.C. H300
P.O. Box 5043
Southfield, MI 48086-5043

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.

You may request to change your primary care physician effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

Instructions for completing the *Blue Cross Personal Choice/BCN Primary Care Physician Selection* form on Page 4

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen, Enter a taxpayer identification number in the Social Security number field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter each member's last and first name, physician's last name and first name, physician's NPI number, physician's address and the reason for changing your primary care physician, 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 **bcbsm.com/find-a-doctor**.
- 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 *Blue Cross Personal Choice/BCN Primary Care Physician* form with your *New Subscriber Enrollment* form when enrolling with Blue Cross or BCN.

Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status ☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network (see instructions on Page 7)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date

Subscriber information (*Indicate changes only)

☐ Non U.S. citizen	Subscriber Social Security number/TIN (required)	Subscriber last name (required)	Subscriber first name (required)	M.I.*	Date of birth*	Marital status* ☐ S ☐ M	Gender* ☐ M ☐ F

New home street address*	City*	State*	ZIP code*	Email*

County*	Country – if other than USA*	New primary phone* ☐ Home ☐ Work ☐ Cell	New secondary phone* ☐ Home ☐ Work ☐ Cell

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Non U.S. citizen	Social Security number/TIN (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 have other health care 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,health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

☐ FSA ☐ HRA ☐ HSA ☐ HSA opt out Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code

Check reason for change below:
☐ Marriage ☐ Loss of eligibility (prior coverage) ☐ COBRA enrollment
☐ Dependents ☐ Name change ☐ Open enrollment ☐ Address change
☐ Transfer old group division/subgroup _____ New group division/subgroup _____
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 Blue Cross or BCN)	Contract holder name	Policy number	Termination date

Are any listed members enrolled in Medicare? ☐ No ☐ Yes If "Yes", check reason category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD
☐ Medicare primary ☐ Subscriber ☐ Spouse
☐ Blue Cross or BCN primary ☐ Dependent
Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC number: _____

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

- Indicate if enrolling in Blue Cross or Blue Care Network. If enrolling with Blue Cross Personal Choice or with BCN, you are also required to complete the *Blue Cross Personal Choice/BCN Primary Care Physician* form on Page 4 to designate your primary care physician.
- Enter Blue Cross group and division number (for example, suffix, section code) or BCN group number, subgroup number and class number. Have your employer's HR representative sign and date the "*Employer signature"* section.

Subscriber information:

- If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx).
- Enter new home address beginning with street address, city, state and ZIP code. Enter email address to receive health and wellness information.
- 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, middle initial, male or female, date of birth. If the responsible individual is not a U.S. citizen, check the box for non-U.S. citizen. Enter a taxpayer identification number in the "Social Security/TIN number" field if the responsible individual checked the box as a non-U.S. citizen. For a U.S. citizen, enter the nine-digit Social Security number (required for all members) of the responsible individual (Example xxx-xx-xxxx). Enter the relationship code of the member(see below).

Relationship codes:

N - Child (by birth or adoption)	A - Child adoption in process **	C - Court order coverage (QMCSO)**	SP - Spouse
S - Stepchild	L - Legal guardianship **	D - Disabled child***	DP - Domestic partner *
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 have 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, health reimbursement and flexible spending account options:

- Check all applicable options. Blue Cross only: See Page 8 for four-digit product indicator code. Return to Page 2 or 6 and enter the four-digit Blue Cross product indicator code.

Employer/group use only:

- Enter employer or group name and employee reference ID or department number, if applicable. Enter benefit code (service code, package code). For the plan code field, enter "710" to represent Blue Cross Blue Shield of Michigan. 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. If transfer, please indicate the old group/division/subgroup and new group division/subgroup numbers.
- For loss of eligibility (prior coverage), indicate "Yes" or "No". If "Yes", please indicate the carrier name, contract holder name, policy number an termination date. If coverage is lost from an insurance carrier other than Blue Cross or BCN, then a letter of credible coverage is required.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If "Yes", check the reason category to explain the member's enrollment in Medicare. Indicate if Medicare is primary or if Blue Cross or BCN is primary 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.

Blue Cross Blue Shield Blue Care Network of Michigan

Blue Cross Blue Shield of Michigan Health Savings and Flexible Spending Account Options

If you are enrolling in a health savings and flexible spending account, please indicate below which options you are selecting by checking all appropriate boxes. Record your selections and the corresponding product indicator code on Page 2 for new enrollments or on Page 6 for a change of status in the "Health savings and flexible spending account options" section of the form. If you have selected an FSA product, please indicate your designated goal amount on Page 2 or Page 6 of the form.

Product selections

Product selected (Check box)	Product name	Product indicator code
☐	High deductible without HSA	0000
☐	HSA	1000
☐	HSA with limited purpose FSA	1070
☐	HSA with dependent care FSA	1004
☐	HSA with limited purpose FSA and dependent care FSA	1074
☐	HSA with limited purpose HRA	1600
☐	HRA	0100
☐	HRA with limited purpose FSA	0170
☐	HRA with dependent care FSA	0104
☐	HRA with limited purpose FSA and dependent care FSA	0174
☐	HRA with FSA	0110
☐	HRA with FSA and dependent care FSA	0114
☐	PPO without health care FSA	0000
☐	Health care FSA	0010
☐	Dependent care FSA	0004
☐	Health care FSA and dependent care FSA	0014