Blue Cross Blue Shield Blue Care Network of Michigan

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

# 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 | Social Security/TIN number (required) | Subscriber legal last name | Subscriber legal first name | M.I.* | Date of birth* | Marital status* ☐ S ☐ M | Gender* ☐ M ☐ F |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

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

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

List all persons to be added or deleted:

| | Legal last name | Legal first name | M. | Gender | Date of birth | Non U.S. citizen | Social Security/TIN 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 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 ☐ HAS ☐ HSA Opt out Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel Goal amount:

## 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 (including Blue Cross and BCN) | Contract holder name | Policy number | Termination date |
|---|---|---|---|
| | | | |

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

* = Attached 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," lit 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 enrolment (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 and 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 BC 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.**