



**ENROLLMENT/
CHANGE OF STATUS**

SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4

Social Security Number/Contract Number	Subscriber Last Name	Subscriber First Name	MI
Home Street Address	City	State	Area Code/Home Phone
Zip Code	County	Current Marital Status	Area Code/Work Phone
		<input type="checkbox"/> Single <input type="checkbox"/> Married	

SECTION 2

List all persons to be enrolled / terminated:

Circle One	LAST NAME	FIRST NAME	M	S	DATE OF BIRTH	SOCIAL SECURITY #	PREVIOUS BCBSM/POS AFFILIATION	PCP CHANGE REASON - BCN/POS ONLY
ADD			X		MMDDYY	XXXXXX	BCBSM BCN POS	
Dep-1			<input type="checkbox"/>	<input type="checkbox"/>				
Dep-2			<input type="checkbox"/>	<input type="checkbox"/>				
Dep-3			<input type="checkbox"/>	<input type="checkbox"/>				

*** Relationship Code**
 N - Child (by Birth or Adoption) P - Principal Support SD - Sponsored Dependent
 S - Stepchild A - Child Adoption in Process C - Court Order Coverage (OMCSO)**
 F - Family Continuation 19+ L - Legal Guardianship** D - Disabled Child (PA 275)***
 * = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement

If the permanent address of the spouse or dependent is different from address in section one, please complete information below:
 Spouse/Dependent (Full name) Street Address City State Zip code

SECTION 3

Do you, your spouse or dependent(s) maintain other health coverage? NO YES

If Yes, complete below:

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 enrolled in Medicare? No Yes **If Yes, attach a copy of Medicare card(s).** Actively working Retired Under 65 ESRD (End Stage Renal Disease)

SECTION 4

I have read and understand the conditions on page 1 of this form.

Subscriber Signature _____ Signature Date _____ Remarks _____

SECTION 5

GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES

BCBSM Group/Suffix or BGN Group I.D. / Subgroup I.D. BCBSM Service Code/BCN Class I.D. Employee I.D. Badge #/Group Name Group Representative Signature Date

Blue Care Network Plan: Medical Rx Hearing Vision Dental

BCBSM Coverage: Traditional/CMM POS PPO Dental Only Vision Only

ENROLLMENT: Effective Date: _____ Date of Hire or Full Time Status: _____

REASON FOR CHANGE: Effective Date: _____

CANCEL COVERAGE: Last Date of Coverage: _____

COBRA ENROLLMENT: Original Qualifying Date: _____

MEDICARE STATUS: Effective Date: _____

REASON: Marriage Duplicate ID Card Name Change Address Change
 Divorce Death Other _____
 Retired Other Insurance
 Contract COBRA Dependent Over Age Left Employment
 Spouse Divorce Death Other _____
 Dependent(s) list in Section 2
 FCR/DCCR Transfer
 Loss of Coverage (Certificate of Creditable Coverage Required) PCP Change
 HIPAA Qualifying Event (describe event): _____
 Termination Layoff Divorced/Legal Separation
 Reduction of Hours Deceased Subscriber Loss of Dependent Status
 Medicare Primary per MSP Law(s) BCBSM/BCN Primary per MSP Law(s) **Please attach a copy of Medicare card(s)**