Blue Cross Blue Shield Blue Care Network of Michigan

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(see Page 3 for instructions) ☐ BCBSM ☐ BCN Members - Complete Page 4 for PCP Selection

BCBSM group number	Division	BCN group ID	Subgroup	Class ID	Employer representative signature

Subscriber information

Date	Social Security 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	E-mail

List all persons to be covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*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 dependents maintain other 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 and flexible spending account options

☐ HSA ☐ HSA Opt out ☐ BCBSM Product indicator code: ☐ Add ☐ Change ☐ Cancel ☐ FSAMED Goal amount: ☐ FSADEPCA Goal amount:

Employer/Group use only

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

Check coverage if applicable: ☐ Medical ☐ Vision ☐ Dental

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

Old group division/subgroup _____ ☐ Retiree ☐ Surviving spouse

New group division/subgroup _____ ☐ Hourly ☐ Open enrollment

Average hours worked per week (required): _____

Job title (required): _____

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

Previous contract number

Original qualifying date

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

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ BCBSM or BCN primary	Medicare A effective date	Medicare B effective date	Medicare Part D effective date