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 US citizen	Subscriber Social Security number (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	Relationship code (See instructions for codes)

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Non US citizen	Social Security number (required)	
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 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:

Health savings,health reimbursement and flexible spending account options Blue Cross only: 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
Metro Electric				

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 you are enrolled in Blue Cross of Michigan or Blue Care Network. If BCN, you are also required to complete the *BCN Primary Care Physician Selection* form on page 4 if you're changing 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 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, if changed.
- 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 , 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, check box if non US citizen, Social Security number (SSN - required for all members) and relationship code (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 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.

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, employer reference ID or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (Blue Cross plan servicing this contract). Enter date of hire and effective date.
- Indicate the reason for change. Check the applicable box. If transfer, please indicate the old group division/subgroup and new group division/subgroup numbers.
- 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 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 somewhere else 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 category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary and enter effective date of the Medicare Part A, B, and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation required for enrollment.