Blue Cross Blue Shield Blue Care Network of Michigan

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

Subscriber new enrollment (see Page 3 for instructions)

☒ Blue Cross Blue Shield of Michigan ☐ Blue Care Network (Also complete Page 4 for primary care physician selection)

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

Subscriber information

Date	☐ Non US citizen	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	Non US Citizen	Social Security 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 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	Date of hire	Effective date
Metro Electric						

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

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

Old group division/subgroup _____ New group division/subgroup _____

☐ Retiree ☐ Surviving spouse ☐ 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 ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ Spouse ☐ BCBSM or BCN primary ☐ Dependent name:	Medicare A effective date	Medicare B effective date	Medicare Part D effective date

Instructions for completing *Subscriber new enrollment* form on Page 2

- Indicate if enrolling in Blue Cross or Blue Care Network: If enrolling with BCN, you are also required to complete the *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 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 for member outreach (such as health and wellness).
- Enter county name for home address, 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, date of birth, check box if non US citizen, Social Security number (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, employee 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.
- 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 somewhereelse 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 under which the member is enrolled 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.