



ENROLLMENT / CHANGE OF STATUS

SECTION 1

SUBSCRIBER / EMPLOYEE INFORMATION
Social Security, Last Name, First Name, MI, Home Street Address, Check if new, City, State, Zip Code, County, Hire Date (Full-time), Area Code/Home Phone, Area Code/Work Phone, Current Marital Status, Single, Married, BUSDRI, CUST, PARA, PROF, SEC, TECH

SECTION 2

List individual(s) to be enrolled or changed:
Table with columns: Grade, LAST NAME, FIRST NAME, DATE OF BIRTH, SOCIAL SECURITY #, PHYSICIAN NAME, HAP PGP CODE, MEDICAL CENTER OR PHYSICIAN NETWORK CODE
Relationship Codes: N - Child (by Birth or Adoption), S - Steppchild, F - Family Continuation 19 + 25, P - Principal Support, A - Child Adoption Process, L - Legal Guardianship, SD - Sponsored Dependent, C - Court Order Coverage (QMCSSO), D - Disabled Child (PA 275)
Previous BCBSM / BCN / HAP Affiliation: I have previously been enrolled in (check applicable box): Blue Cross Blue Shield of Michigan, Blue Care Network, Health Alliance Plan

SECTION 3

Do you, your spouse or dependent(s) maintain other health coverage?
Person covered (Full name), Group, Policy Number, Carrier, Location
Are you, your spouse or any dependent(s) enrolled in Medicare?
Health: HAP, BCBS Comprehensive, BCBS PPO, BCBS Traditional

SECTION 5

CANCEL COVERAGE: Last Date of Coverage, Reason, Open Enrollment, Change in Family Status, Divorce, Other
MODIFY CURRENT COVERAGE: Effective Date, Reason, Marriage, Name Change, Request ID card, Dependent(s), Address Change, Change in Primary Care Physician (PCP)
COBRA ENROLLMENT: Original Qualifying Date, Reason, Termination / Cancellation per contract, Deceased Employee, Loss of Dependent Status, Divorce / Legal Separation
MEDICARE STATUS: Effective Date, Medicare Primary per MSP Law(s), BCBSM / BCN / HAP Primary per MSP Law(s)

SECTION 6

Subscriber / Employee Signature, Signature Date, Remarks, Business Department use only, Group / Suffix, Group Name, Macomb Intermediate School District, Group Representative Signature, Date

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE OTHER SIDE OF THIS APPLICATION.

THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM), BLUE CARE NETWORK OF MICHIGAN (BCN) OR HEALTH ALLIANCE PLAN.

HAP APPLICATION

I apply on behalf of myself and eligible family members, as listed, for enrollment in and for the health services provided to members of health Alliance Plan, which is now available through my employer's insurance program. I hereby revoke all previous enrollment applications executed by me for hospital and medical expense coverage as made available by my employer.

I may enroll my unmarried children legally residing with me who are either my own, or legally adopted, or those of my spouse by a previous marriage as defined below.

I may list unmarried dependent children between age 19 and 25. Such children are covered to December 31 of the year in which they turn 25, as long as they reside with me, or, if residing elsewhere are full-time students; and they are dependent on me for more than half of their support as defined by the Internal Revenue Code.

I understand that unmarried children, disabled before age 19 are considered to be dependent children and covered to any age. Such children must be incapable of self-sustaining employment by reason of mental retardation or physical handicap; dependent upon me for more than half their support as defined by the Internal Revenue Code; and must have previous coverage. I understand that I must provide medical documentation verifying the disability.

I understand that I and my dependents will not be eligible for hospital admissions, doctor's services and other covered services until the effective date of my membership as determined by Health Alliance Plan and my employer.

I authorize persons rendering medical or hospital care and related service (including hospitals and medical groups contracting with Health Alliance Plan) to provide records and other information concerning such care or services to Health Alliance Plan.

Whenever the full subscription rate is not paid by my employer, I authorize my employer to periodically deduct in advance from my wages and to remit to Health Alliance Plan, the amount necessary to pay the periodic rate.

The subscriber may cancel this application within 72 hours after signing by sending written notice to Health Alliance Plan or their employer.

BCBSM APPLICATION

I am applying for coverage for myself and my family members identified on this application under my group or association's contract with BCBSM/BCN. Coverage begins on the date determined by BCBSM/BCN accepts my application, I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM/BCN.

Authorization: I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone covered under the policy. I authorize BCBSM/BCN, and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM/BCN, and for other purposes necessary for BCBSM/BCN to fulfill its contractual and statutory obligations.

Release of Information: BCBSM does not require your Social Security Number; however, your group or association, Medicare, Medicaid and others do require it. BCN requires the Social Security Number of each subscriber. In applying for coverage, we agree to permit providers and others to release protected health information to BCBSM for purposes of administering our coverage. Upon your request, BCBSM/BCN will tell you where the information was sent.

COBRA: You will not be eligible for a waiver of any preexisting exclusion in BCBSM non-group coverage if you do not elect and exhaust any COBRA coverage available to you.

BLUE CARE NETWORK ONLY

I and my enrolled family members agree that all of our medical services must be performed, prescribed, directed or authorized by our designated BCN primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency when the time needed to contact our Primary Care Physician may mean permanent damage to our health. Unauthorized services that are not an immediate emergency, as described above, received from non-Blue Care Network providers will not be covered.

The BCN service area excludes Branch, Lake, Lenawee, Mason, Missaukee, Osceola and Sanilac counties. Residents of these counties may receive services in a BCN covered county by providing BCN with an Out of Area Waiver at the time of enrollment.

I agree to assign to BCN my entire right of recovery of the cost of hospital, medical and prescription services delivered by or paid for by BCN against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts whether by redemption award or voluntary payment or otherwise.

I authorize any holder of medical or other information, about me or my enrolled family members, to release to the centers for Medicare and Medicaid services, any insurance company, or any HMO and their agents any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to Blue Care network on my behalf for any services furnished to me and enrolled family members by Blue Care Network.