ENROLLMENT / CHANGE OF STATUS

SECTION 1 — SUBSCRIBER / EMPLOYEE INFORMATION

Social Security	Last Name ☐ Check if new	First Name	MI
			L

Home Street Address ☐ Check if new	City	State	Zip Code	County

Current Marital Status ☐ Single ☐ Married	Hire Date (Full-time)	Area Code/Home Phone	Area Code/Work Phone

UNION: ☐ BUSDR ☐ CUST ☐ PARA ☐ PROF ☐ SEC ☐ TECH

SECTION 2

List individual(s) to be enrolled or changed:

	Select One	LAST NAME	FIRST NAME	M. I.	Gender	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	Relationship Code
Subscriber	○ Add ○ Delete				☐ M ☐ F			
Spouse	○ Add ○ Delete				☐ M ☐ F			
Dep-1	○ Add ○ Delete				☐ M ☐ F			
Dep-2	○ Add ○ Delete				☐ M ☐ F			
Dep-3	○ Add ○ Delete				☐ M ☐ F			

*** Relationship Codes**

N - Child (by Birth or Adoption)
S - Stepchild
F - Family Continuation 19 + 25
P - Principal Support [1]
A - Child Adoption Process [2]
L - Legal Guardianship [2]
SD - Sponsored Dependent
C - Court Order Coverage (QMCSO) [2]
D - Disabled Child (PA 275) [3]

[1] = Attach Documentation [2] = Attach Court Order [3] = Attach Physician Statement

Previous Carrier

I have previously been enrolled in (check applicable box) :

☐ Blue Cross Blue Sheild of Michigan ☐ Blue Care Network ☐ Health Alliance Plan

☐ Other _____ Enter contract # _____

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 dependent(s) enrolled in Medicare ? ☐ NO ☐ YES If Yes, attach a copy of Medicare card(s).

SECTION 5

Complete the following information for individuals listed in Section 2.

ENROLLMENT: Effective Date: Reason: ☐ New Hire ☐ Return from Leave ☐ Open Enrollment ☐ Change in Familiy Status

☐ BCBS Comm Blue (Primary Plan) ☐ BCBS Comm Blue (Optional Plan) ☐ BCBS Simply Blue (HSA Plan) ☐ BCBS Comm Blue (Pilot Plan)
☐ BCBS Simply Blue (Bronze Plan) ☐ Cafeteria Plan Allowance (FSA Only Plan)

CANCEL COVERAGE: Last Date of Coverage: Reason: ☐ Open Enrollment ☐ Change in Familiy Status ☐ Divorce ☐ Other_____

☐ BCBS Comm Blue (Primary Plan) ☐ BCBS Comm Blue (Optional Plan) ☐ BCBS Simply Blue (HSA Plan) ☐ BCBS Comm Blue (Pilot Plan)
☐ BCBS Simply Blue (Bronze Plan) ☐ Cafeteria Plan Allowance (FSA Only Plan)

MODIFY CURRENT COVERAGE: Effective Date: Reason: ☐ Marriage ☐ Name Change ☐ Request ID card ☐ Dependent(s) ☐ Address Change

COBRA ENROLLMENT: Original Qualifying Date: Reason: ☐ Termination / Cancellation per contract ☐ Deceased Employee ☐ Loss of Dependent Status ☐ Divorce / Legal Separation

☐ BCBS Comm Blue (Primary Plan) ☐ BCBS Comm Blue (Optional Plan) ☐ BCBS Simply Blue (HSA Plan) ☐ BCBS Comm Blue (Pilot Plan) ☐ BCBS Simply Blue (Bronze Plan)

MEDICARE STATUS: Effective Date: ☐ Medicare Primary per MSP Law(s) ☐ BCBSM Primary per MSP Law(s)

SEC. 6

Subscriber / Employee Signature

Signature	Signature Date	Remarks

Business Department use only

Group / Suffix	Group Name	Group Representative Signature	Date
	Macomb Intermediate School District		

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.