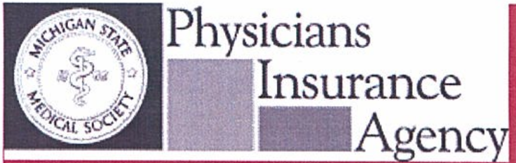

Wayne State School of Medicine

BCN – HMO and BCBSM - PPO

Subscriber Information					
Social Security Number	Student ID#	Subscriber Last Name		Subscribers First Name	MI
Street Address		City		State	Zip Code
Area Code/ Phone Number	Birth Date ____/____/__________	Male or Female _____/______	Single or Married _____/______	Email Address ___________________@med.wayne.edu	

List all Dependants to be enrolled or terminated				
Check One	**Last Name**	**First Name**	**Birth Date**	**Social Security #**
Spouse Add____ Delete____			____/____/________	
Dependant 1 Add____ Delete _____			____/____/________	
Dependant 2 Add____ Delete _____			____/____/________	

HMO SUBSCRIBERS ONLY				
	Physician Name	Physician's #	Physicians Location	Seen this Physician in the last 12mo
Subscriber				Yes ______ No_____
Spouse				Yes______ No_____
Dependant 1				Yes______ No______
Dependant 2				Yes_____ No_______

I have read and understand the conditions on the reverse side of this form	Check Coverage Choice, Number of Insured, and Your School Year		
Sign and Date Here	Coverage Choice	Number of Insured	Level of Training
	PPO High _______	1 – Person _______	Year 1 ________
Enrollment Date:	PPO Med _______	2 – Person _______	Year 2 ________
Cancel Date:	PPO Basic ______	Family _________	Year 3 _________
	HMO __________		Year 4 _________

Enrollment Change of Status Form (ECOS)

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE ATTACHED ENROLLMENT CHANGE OF STATUS FORM.

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

I am applying for coverage for myself and my family members identified on this application under my group's or association's contract with BCBSM or BCN (BCBSM/BCN). Coverage begins on the date determined by BCBSM/BCN. When 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. It 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: I acknowledge that BCBSM/BCN requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM/BCN for purposes of administering our coverage. Upon my request, BCBSM/BCN will tell me where the information was sent.

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

If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer I authorize BCBSM/BCN to provide claims information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

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(s) 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 and 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 BCN on my behalf for any services furnished to me and my enrolled family members by BCN.