

**SECTION 1 SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 3**

|  |                |  |  |                                 |
|--|----------------|--|--|---------------------------------|
| Subscriber Social Security   | Student I.D. # | Subscriber Last Name (check if new) <input type="checkbox"/>                               | Subscriber First Name  | MI                              |
| Street Address you want Health Insurance Mailed to (check if new) <input type="checkbox"/> |                | City   | State  | Area Code/ Home Phone           |
| Zip Code   | County         | Current Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth<br>____/____/____ |
| E-Mail Address   |                | E-Mail Address<br>@med.wayne.edu   |  |                                 |

**SECTION 2 SUBSCRIBER**

List all persons to be enrolled / terminated:

| CIRCLE ONE    | LAST NAME | FIRST NAME | MI | SEX | Date of Birth<br>MMDDYYYY | SOCIAL SECURITY # |
|---------------|-----------|------------|----|-----|---------------------------|-------------------|
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |
| Add<br>Delete |           |            |    |     | ____/____/____            |                   |

**SECTION 3 SIGNATURE**

I have read and understand the conditions on the reverse side of this form.

|                      |                |         |
|----------------------|----------------|---------|
| Subscriber Signature | Signature Date | Remarks |
|----------------------|----------------|---------|

**SECTION 4 GROUP USE ONLY**

|                    |                        |
|--------------------|------------------------|
| BCBSM Group/Suffix | Effective Date:        |
| ENROLLMENT:        | Effective Date:        |
| REASON FOR CHANGE: | Last Date of Coverage: |
| CANCEL COVERAGE:   |                        |

Please indicate coverage, number of insured, and year:

| Coverage Choice | Contract Information | Level of Training |
|-----------------|----------------------|-------------------|
| Basic           | 1-Person             | Year 1            |
| Medium          | 2-Person             | Year 2            |
| High            | Family               | Year 3            |
|                 |                      | Year 4            |

**INSTRUCTIONS FOR COMPLETING ENROLLMENT/CHANGE OF STATUS FORM  
ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED**

**SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-3**

**SECTION 1:** Enter subscriber information including: Social Security, student I.D. number, last name, first name, middle initial, street address you want health insurance mailed to, marital status, sex, date of birth, day phone number, and your email address with Wayne State School of Medicine.

**SECTION 2:** List all persons that you wish to add/*or* delete. **ATTACH ADDITIONAL ENROLLMENT FORMS IF NECESSARY TO ADD MORE DEPENDENTS.** Include sex, birthdate, and Social Security number.

**SECTION 3:** You must sign the form and indicate date form is completed.

**SECTION 4: GROUP IS REQUIRED TO COMPLETE SECTION 4** (This form cannot be processed for enrollment purposes without completion of the following):

Enrollment: Indicate BCBSM effective date. Check all applicable enrollment boxes. These special enrollment periods include enrollment or changes as the result of marriage, birth, adoption, or placement of adoption, loss of eligibility or termination of group contributions.

Reason To change a subscriber/dependent(s) health care coverage, indicate BCBSM effective date.

**PLEASE PROVIDE ALL DOCUMENTATION FOR ENROLLMENT**