



New Subscriber Enrollment

Blue Cross Blue Shield of Michigan Blue Care Network

(see Page 3 for instructions) (Also complete Page 4 for Personal Choice or primary care physician selection)

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

Date	<input type="checkbox"/> Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber birth date	Home street address		City		State	ZIP code	
County	Country - if other than USA	Primary telephone number	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary telephone number	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Email	

List all persons to be covered:

	Legal last name	Legal first name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Non U.S. citizen <input type="checkbox"/>	Social Security/TIN number (required)	*Relationship code (see instructions for codes)
Spouse								
Dep. 1								
Dep. 2								
Dep. 3								
Dep. 4								

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
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Coordination of benefits information

Do you, your spouse or dependents have other health care 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
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I have read and understand the conditions of this form. Subscriber signature: _____

Date: _____

Health savings, health reimbursement and flexible spending account options for only Blue Cross coverage: See Page 8 for product selections

FSA HRA HSA HSA Opt out Blue Cross product indicator code Add Change Cancel Goal Amount: _____

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date
Check coverage if applicable: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy	Check type of enrollment: <input type="checkbox"/> New <input type="checkbox"/> Full time <input type="checkbox"/> Rehire <input type="checkbox"/> Part time	<input type="checkbox"/> Transfer <input type="checkbox"/> Return from layoff Old group division/subgroup _____ New group division/subgroup _____	<input type="checkbox"/> Loss of eligibility (prior coverage) <input type="checkbox"/> Retiree <input type="checkbox"/> Hourly	<input type="checkbox"/> Salary <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Open enrollment	Average hours worked per week (required): _____	Job title (required): _____
COBRA enrollment Check reason: <input type="checkbox"/> Termination <input type="checkbox"/> Layoff	<input type="checkbox"/> Reduction of hours <input type="checkbox"/> Loss of dependent status	<input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Deceased subscriber	Previous contract number	Original qualifying date		
Loss of eligibility (prior coverage) <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete:	Carrier's name (Including Blue Cross and BCN)	Contract holder name	Policy number	Termination date		
Are any members listed enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", check reason category <input type="checkbox"/> Over 65 and working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD HIC number: _____						
<input type="checkbox"/> Medicare primary <input type="checkbox"/> Blue Cross or BCN primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent name: _____	Medicare A effective date	Medicare B effective date	Medicare Part D effective date		