Blue Cross Blue Shield Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

New Subscriber Enrollment

(see Page 3 for instructions)

☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network

(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

Subscriber information

Date	☐ Non U.S. citizen	Social Security/TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status ☐ S ☐ M	Gender ☐ M ☐ F

Subscriber birth date	Home street address	City	State	ZIP code

County	Country - if other than USA	Primary telephone number	☐ Home ☐ Work ☐ Cell	Secondary telephone number	☐ Home ☐ Work ☐ Cell	Email

List all persons to be covered:

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

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

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

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 coverge if applicable: ☐ Medical ☐ Vision ☐ Dental ☐ Pharmacy

Check type of enrollment: ☐ New ☐ Full time ☐ Rehire ☐ Part time ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Salary ☐ Retiree ☐ Surviving spouse ☐ Hourly ☐ Open enrollment

Old group division/subgroup _____

New group division/subgroup _____

Average hours worked per week (required): _____

Job title (required): _____

COBRA enrollment Check reason: ☐ Termination ☐ Layoff ☐ Reduction of hours ☐ Loss of dependent status ☐ Divorce or legal separation ☐ Deceased subscriber

Previous contract number

Original qualifying date

Loss of eligibility (prior coverage) ☐ Yes ☐ 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? ☐ No ☐ Yes If "Yes", check reason category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ Subscriber ☐ Spouse ☐ Blue Cross or BCN primary ☐ Dependent name:	Medicare A effective date	Medicare B effective date	Medicare Part D effective date