Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status ☐ Blue Cross Blue Shield of Michigan ☐ Blue Care Network (see instructions on Page 7)

Blue Cross group number	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date

Subscriber information (*Indicate changes only)

☐ Non US citizen	Subscriber Social Security number (Required)	Subscriber last name (Required)	Subscriber first name (Required)	M.I.*	Date of birth*	Marital status*	Gender*
						☐S ☐M	☐M ☐F

New home street address*	City*	State*	ZIP code*	Email*

County*	Country – if other than USA*	New primary phone* ☐Home ☐Work ☐Cell	New secondary phone* ☐Home ☐Work ☐Cell	Relationship code (See instructions for codes)

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Non US citizen	Social Security number (required)	Relationship code (See instructions for codes)
Spouse Add Delete				☐M ☐F		☐		
Dep. 1 Add Delete				☐M ☐F		☐		
Dep. 2 Add Delete				☐M ☐F		☐		
Dep. 3 Add Delete				☐M ☐F		☐		
Dep. 4 Add Delete				☐M ☐F		☐		

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents maintain other health 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 Blue Cross only: See page 8 for product selections

☐ FSA ☐ HRA ☐ HSA ☐ HSA opt out Blue Cross product indicator code ☐ Add ☐ Change ☐ Cancel

Employer/group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code

Check reason for change below:
☐Marriage ☐Loss of eligibility (prior coverage) ☐COBRA enrollment
☐Dependents ☐Name change ☐Open enrollment ☐Address change
☐Transfer old group division/subgroup _____ New group division/subgroup _____
Date of event: _____ Effective date: _____

Check type of cancellation and reason below. Type: ☐Contract ☐Spouse ☐Dependents
Reason: ☐COBRA ☐Death ☐Left employment
☐Divorce ☐Dependent over age ☐Other
☐Retired ☐Other insurance
Last date of coverage: _____

Loss of eligibility (prior coverage)? ☐Yes ☐No If Yes, complete below:

Carrier's name (includes Blue Cross or BCN)	Contract holder name	Policy number	Termination date

Are any listed members enrolled in Medicare? ☐No ☐Yes If Yes, check reason category ☐Over 65 and working ☐Retired ☐Disabled ☐ESRD
☐Medicare primary ☐Subscriber ☐Spouse Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC number: _____
☐Blue Cross or BCN primary ☐Dependent