

# Enrollment/Change of Status Form

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Enter Social Security or Assigned Contract Number

**SECTION 1**  
SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4

Social Security Number/Contract Number: \_\_\_\_\_ Subscriber Last Name: \_\_\_\_\_  check if new  
Subscriber First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Area Code/Home Phone: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Current Marital Status:  Single  Married  
Area Code/Work Phone: \_\_\_\_\_

**SECTION 2**  
ENROLLMENT/CHANGE OF STATUS

List all persons to be enrolled/terminated:

Order	Relationship	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM/DDYY	SOCIAL SECURITY #	PCP LAST NAME	PCP PHYSICIAN #	PCP PHYSICIAN LOCATION	Signature	Date
1	Subscriber										
2	Spouse										
3	Dep 1										
4	Dep 2										
5	Dep 3										

**Relationship Code**  
 N - Child (by Birth or Adoption) P - Principal Support\* SD - Sponsored Dependent\*  
 S - Stepchild A - Child Adoption in Process\*\* C - Court Order Coverage (CMCSO)\*\*  
 F - Family Continuation 10+ L - Legal Guardianship\*\* D - Disabled Child (PA 275)\*\*

**Previous BCBSM/POS Affiliation**  
 I have previously been enrolled in:  
 BCBSM  BCN  POS  
 Enter contract # \_\_\_\_\_

**PCP Change Reason - BCN/POS ONLY**  
 Use current physician directories for this required selection or access our directory on our Internet site at [www.BCBSM.com](http://www.BCBSM.com)

**SECTION 3**  
GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES

BCBSM Group/Suffix or BCN Group I.D./ Subgroup I.D.: \_\_\_\_\_ BCBSM Service Code/BCN Class I.D.: \_\_\_\_\_ Employee I.D./Badge #/Group Name: \_\_\_\_\_ Group Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COVERAGE PLAN**  
 Blue Care Network Plan:  Medical  No  Hearing  Vision  Dental  
 BCBSM Coverage:  Traditional/COM  POS  PPO  Dental Only  Vision Only

**REASON FOR CHANGE**  
 Effective Date: \_\_\_\_\_  
 Marriage  Divorce  COBRA  Name Change  Address Change  
 Dependent(s)  Loss of Coverage/Certificate of Creditable Coverage Requested  PCP Change  HIRMA Qualifying Event (describe event): \_\_\_\_\_  
 ROLYDCOR  Termination  Retired  Other Insurance

**COBRA (IF APPLICABLE)**  
 Original Qualifying Date: \_\_\_\_\_  
 Termination  Layoff  Divorce/Legal Separation  
 Reduction of Hours  Disabled Subscriber  Loss of Dependent Status  
 Previous Contract # \_\_\_\_\_

**MEDICARE STATUS**  
 Effective Date: \_\_\_\_\_  
 Medicare Primary per MSP Law(s)  BCBSM/BCN Primary per MSP Law(s) Please attach a copy of Medicare card(s)

Attach supporting documentation to verify member's eligibility as instructed

Subscriber signature required

BCBSM 8-digit group/suffix number or BCN group I.D./subgroup I.D.

Date BCBSM/BCN/POS coverage will begin

Date of marriage, birth, etc.

The subscriber's coverage will remain in effect through his or her cancellation date as indicated

There should be no break in coverage between the cancellation date and the COBRA qualifying date.

Your 12-digit BCBSM service code or 4-digit BCN class I.D.

Indicate badge number if applicable

Contract termination: Cancels all subscriber and dependent coverage  
 Spouse termination: Cancels the coverage of the spouse only  
 Dependent termination: Cancels the coverage of dependents only

BCN/POS Use current physician directories for this required selection or access our directory on our Internet site at [www.BCBSM.com](http://www.BCBSM.com)

Indicate reason for changing PCP

Indicate BCN coverage selected

Form cannot be processed without group representative's signature

Indicate BCBSM coverage selected

# Blue Cross Blue Shield/Blue Care Network/ Point of Service

Find the type of change you're requesting, then follow the instructions listed immediately below its category.

## New enrollments

Please submit to BCBSM/BCN/POS within 30 days of effective date

### Subscriber completes the following portions of sections 1, 2, 3, 4:

- Subscriber personal information
- Spouse/dependent(s) personal information
- Address information, if applicable
- Other coverage, if applicable
- Subscriber signature and date

### Group completes section 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- BCBSM group service code or BCN class I.D., if known
- Badge number if applicable
- Group name
- Group representative's signature and date
- Coverage/Plan (BCBSM/BCN/POS)
- Enrollment effective date
- Date of hire or full-time status
- Type of enrollment and enrollment status

## Contract changes

Please submit to BCBSM/BCN/POS within 30 days of event

A contract change includes the birth of a child, marriage, adoption or legal guardianship. (Documentation may be required.)

### Subscriber completes the following portions of sections 1, 2, 3, 4:

- Subscriber personal information
- New spouse/dependent(s) personal information
- Spouse/dependent(s) personal information, if applicable
- Medicare information, if applicable
- Other coverage, if applicable
- Subscriber signature and date

### Group completes section 5:

- Date of event/last day of coverage
- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- BCBSM group service code or BCN Class I.D., if known
- Group name
- Group representative's signature and date
- Reason for change/cancelling coverage
- If cancelling spouse/dependent(s), check appropriate cancellation and reason for cancellation box

## Address changes

Please submit to BCBSM/BCN/POS within 30 days of event

Please list address change(s) for the BCBSM/BCN/POS subscriber or dependents

### Subscriber completes sections 1, 2 and 4:

- Subscriber personal information
- New address information
- Subscriber signature and date

### Group completes section 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- Group name
- Group representative's signature and date
- Reason for change
  - a) Effective date
  - b) Check address change box

## Name changes

Please submit to BCBSM/BCN/POS within 30 days of event

### Subscriber completes sections 1, 2 and 4:

- Social Security Number/Contract Number
- If subscriber, enter new name and check box in section 1
- If spouse/dependent, enter new name in section 2
- Explain change in Remarks section 4
- Subscriber signature and date

### Group completes section 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- Group name
- Group signature and date
- Reason for change
  - a) Effective date
  - b) Check name change box

## Cancellations (Membership Deletions)

Please submit within 30 days of cancellation of contract, or deletion of spouse or dependent(s).

### Group completes sections 1, 2 and 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- Group name
- Group representative's signature and date
- Last date of coverage
- Type of cancellation
- Reason for cancellation

## COBRA enrollments

Refer to COBRA sections for guidelines. This applies to subscriber or any of his/her eligible dependents.

### COBRA subscriber completes the following portions of sections 1, 2, 3, 4:

- Subscriber's personal information
- Spouse and dependent(s) personal information, if applicable
- Other health care coverage, if applicable
- COBRA subscriber must sign the form

### Group completes the COBRA enrollment portion of section 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- BCBSM group service code or BCN class I.D., if known
- Group name
- Group representative's signature and date
- Coverage/Plan
- Original qualifying date. If subscriber is changing carriers during open enrollment, please indicate the original COBRA start date with other carrier
- COBRA qualifying status

## Reinstatements for subscribers

Please submit to BCBSM/BCN/POS within 30 days of effective date

This includes rehires, layoffs and re-enrollments. Groups – please note that the rehire/layoff clause must be defined in the Group Enrollment and Coverage Agreement Part B.

### Subscriber completes the following portions of sections 1, 2, 3, 4:

- Subscriber personal information
- Spouse/dependent(s) personal information
- Address information, if applicable
- Medicare information, if applicable
- Other health care coverage, if applicable
- Subscriber signature and date

### Group completes the following portions of section 5:

- BCBSM group number/suffix or BCN group I.D./subgroup I.D.
- BCBSM group service code or BCN class I.D., if known
- Badge number if applicable
- Group name
- Group representative's signature and date
- Coverage/Plan
- Enrollment effective date
- Date of hire or full-time status
- Type of enrollment and enrollment status

Submit Enrollment/Change of Status Form for each group a subscriber is enrolled or enrolling in