ENROLLMENT/ CHANGE OF STATUS

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 ☐ check if new	City	State	Area Code/Home Phone

Zip Code	County	Current Marital Status ☐ Single ☐ Married	Area Code/Work Phone

SUBSCRIBER SECTION 2

List all persons to be enrolled / terminated:

	Circle One	LAST NAME	FIRST NAME	M I	SEX	DATE OF BIRTH MMDDYY	SOCIAL SECURITY #	* REL CODE	PRIMARY CARE PHYSICIAN NAME - BCN/POS ONLY: LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION	Seen in the last 12 months: YES	NO
Subscriber	Add Delete				☐M ☐F									
Spouse	Add Delete				☐M ☐F									
Dep-1	Add Delete				☐M ☐F									
Dep-2	Add Delete				☐M ☐F									
Dep-3	Add Delete				☐M ☐F									

*** Relationship Code**

N - Child (by Birth or Adoption)
S - Stepchild
F - Family Continuation 19+
P - Principal Support*
A - Child Adoption in Process**
L - Legal Guardianship**
SD - Sponsored Dependent*
C - Court Order Coverage (QMCSO)**
D - Disabled Child (PA 275)***

* = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement

Previous BCBSM/POS Affiliation

I have previously been enrolled in : (Check applicable box)

☐ BCBSM ☐ BCN ☐ POS

Enter contract # ____________

PCP Change Reason - BCN/POS ONLY

____

____

If the permanent address of the spouse or dependent is different from address in section one, please complete information below:

Spouse/Dependent (Full name)	Street Address	City	State	Zip code

OTHER COVERAGE SECTION 3

Do you, your spouse or dependent(s) maintain other health coverage? ☐ NO ☐ YES If Yes, complete below:

Person covered (Full name)	Group	Policy Number	Carrier	Location

Are you, your spouse or any dependents listed in section 2 enrolled in Medicare? ☐ No ☐ Yes **If Yes, attach a copy of Medicare card(s).** ☐ Actively working ☐ Retired ☐ Under 65 ☐ ESRD (End Stage Renal Disease)

SIGNATURE SEC. 4

I have read and understand the conditions on page 1 of this form.

Subscriber Signature	Signature Date	Remarks

GROUP USE ONLY SECTION 5

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 ☐ Rx ☐ Hearing ☐ Vision ☐ Dental **BCBSM Coverage:** ☐ Traditional/CMM ☐ POS ☐ PPO ☐ Dental Only ☐ Vision Only

ENROLLMENT: Effective Date: ____ Date of Hire or Full Time Status: ____
☐ New ☐ Part-Time ☐ Hourly ☐ Retiree ☐ Open Enrollment ☐ Return to work from Layoff
☐ Rehire ☐ Full-Time ☐ Salary ☐ Surviving Spouse ☐ HIPAA Qualifying Event (describe event): ____________

REASON FOR CHANGE: Effective Date: ____
☐ Marriage ☐ Duplicate ID Card ☐ Name Change ☐ Address Change
☐ Dependent(s) ☐ Loss of Coverage (Certificate of Creditable Coverage Required) ☐ PCP Change
☐ FCR/DCCR ☐ Transfer ☐ HIPAA Qualifying Event (describe event): ____________

CANCEL COVERAGE: Last Date of Coverage: ____
☐ Contract ☐ Spouse ☐ Dependent(s) list in Section 2
REASON: ☐ COBRA ☐ Divorce ☐ Retired ☐ Dependent Over Age ☐ Death ☐ Other Insurance ☐ Left Employment ☐ Other ____________

COBRA ENROLLMENT: Original Qualifying Date: ____
☐ Termination ☐ Reduction of Hours ☐ Layoff ☐ Deceased Subscriber ☐ Divorce/Legal Separation ☐ 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)**

CN 3599 MAY 05

WHITE PLY- RETURN TO BCBSM/BCN/POS MEMBERSHIP YELLOW PLY- GROUP PINK PLY- SUBSCRIBER

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