Blue Cross Blue Shield Blue Care Network of Michigan

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

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

List all persons to be added or deleted:

	Legal last name	Legal first name	M.	Gender	Date of birth	Non U.S. citizen	Social Security/TIN 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 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

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 (including Blue Cross and BCN)	Contract holder name	Policy number	Termination date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No — If "Yes," check reason category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD

☐ Medicare primary ☐ Subscriber ☐ Spouse
☐ Blue Cross or BCN primary ☐ Dependent name:

Medicare A effective date _____ Medicare B effective date _____ Medicare Part D effective date _____ Medicare ID: _____