



Individual Billed Member Change of Status Request

Table with 2 columns: GROUP NUMBER, CONTRACT NUMBER

MEMBER CHANGES

Add the following person(s) to my contract:

Reason: Marriage to (marriage license required within 30 days) Birth of (birth certificate required) Other

Remove the following person(s) from my contract:

Reason: Death Divorce Enrolled in Medicare Blue (attach CMS confirmation letter) Other

Table with 8 columns: Last Name, First Name, M.I., Sex, Date of Birth, Social Security Number, Date of Event, *Rel. Code

*Relationship Codes:

- N - Biological/Adopted Child** P - Principal Support (Attach Court Document) C - Court Order Coverage (QMSCO) (Attach Court Order) S - Stepchild A - Child Adoption in Progress (Attach Court Document) D - Disabled Child (PA275) (Attach Physician Statement) F - Family Continuation 19-25 L - Legal Guardianship (Attach Court Document)

Terminate my contract effective next billing period (If moving to a Medicare Plus Blue plan, attach CMS confirmation letter.) If you terminate your coverage, you will not be allowed to enroll in any BCBSM individual market product for 12 months after your termination date.

COVERAGE CHANGES

Change my health care plan to: (Note: plan changes are allowed only at contract anniversary date.)

Traditional plans: Option A Option C

- PPO plans Young Adult Blue Individual Care Blue Plus optional Flexible Blue Dental Plus Flexible Blue II- 1500 Flexible Blue II- 2500 Flexible Blue II- 5000 optional Flexible Blue Dental Plus optional maternity

Dental plans:

Personal Blue Dental Personal Blue Dental Plus

PBD and PBD Plus are available as an option to all products except Individual Care Blue Plus, Flexible Blue II-1500, Flexible II-2500, and Flexible Blue II-5000.

Medicare Supplemental plans: Plan A Plan C Medigap Blue

To enroll in Medicare Advantage (Medicare Plus Blue or Prescription Blue Plans), you must call 1-800-485-4415

Note: If you are under 65 Non-Medicare and changing to a Medicare supplemental plan you must submit a new application.

OTHER CHANGES

Name Change: Last Name First Name Middle Initial

Address Change: Address City State Zip Code

Telephone Number Change:

I certify that the requirements of eligibility are met and that the information I have given on this Change of Status Request is true and correct to the best of my knowledge.

SUBSCRIBER'S SIGNATURE

DATE

Mail all change of status requests to: Blue Cross Blue Shield of Michigan P.O. Box 44407 Detroit MI 48244-0407

Premium payments sent to this address could delay access to your benefits You may Fax to: 1-866-392-7528