

Enrollment/Change of Status Form



Social Security number is used for the subscriber's contract number

The form is titled "ENROLLMENT/CHANGE OF STATUS" and is divided into several sections. Callouts point to the following areas:

- SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4:** Includes fields for Subscriber Social Security, Last Name, First Name, Home Street Address, City, State, Area Code/Home Phone, Zip Code, County, Current Marital Status, Sex, Date of Birth, and Area Code/Work Phone.
- ENROLLMENT/CHANGE OF STATUS:** A table to list all persons to be enrolled/terminated, with columns for Type, Last Name, First Name, M, I, D, E, X, Date of Birth, Social Security #, Primary Care Physician Name, Physician #, and Physician Location.
- Relationship Code:** Includes codes for Child, Spouse, Family Continuation, etc.
- Previous BCBSM/POS Affiliation:** Includes checkboxes for BCBSM, BCN, and POS, and a field for "Enter contract #".
- PCP Change Reason - BCN/POS ONLY:** A field for indicating the reason for changing the Primary Care Physician.
- Do you, your spouse or dependent(s) maintain other health coverage?:** Includes checkboxes for NO and YES, and a section for "If Yes, complete below" with fields for Person covered, Group, Policy Number, and Location.
- GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES:** Includes checkboxes for COBRA Enrollment, Medicare Status, and various coverage options like BCBSM Coverage, Traditional/CSM, POS, PPO, Dental Only, and Vision Only.
- Signature and Date:** Fields for Subscriber Signature, Signature Date, and Group Representative Signature and Date.

Attach supporting documentation to verify member's eligibility as instructed

Subscriber signature required

Your 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

The subscriber's coverage should be without a break 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

Use current physician directories for this required selection or access our directory on our Internet site at 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:

- Spouse/dependent(s) personal information, if applicable
- 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)

BCBSM contract cancellations are noted on the monthly billing reconciliation worksheet.

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's 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
- Type of enrollment and enrollment status
- Date of hire or full-time status