



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Application for Individual Coverage Enrollment/Change of Status Form

**One Blue**<sup>SM</sup>

To be eligible for this coverage you must live in the state of Michigan at least nine months of the year, be under age 65 and not be eligible for Medicare or Medicaid.

Please select a billing frequency for future payments:  Monthly  Quarterly;  Semiannually;  Annually.

If you would like to use automatic payment (ACH) to make your premium payments, please complete the form at the end of this application.

Do not send payment with the application, You will receive an invoice for your first payment.

Requested effective date: Month \_\_\_\_\_  1st  15th

Your application must be received by BCN within 30 days of the signature date. You may select an effective date of the 1st or the 15th of the month. Your requested effective date may not be more than 60 days after the signature date. Your requested effective date is subject to Underwriting approval of your application and may change.

Dependent children must be unmarried, age 19 or younger and a resident of Michigan to be eligible for coverage.

**Part I: Applicant Information**

Applicant Social Security Number		Applicant Last Name			Applicant First Name			M.I.	Area Code/Evening Phone		Area Code/Day Phone		
Street Address (P.O. Box may not be used)					City			State	Zip Code	County		Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Applicant's Drivers License or State ID Number				Issue State	Expiration Date		Spouse's Drivers License or State ID Number			Issue State	Expiration Date		
List all persons to be enrolled/terminated (attach additional sheet if necessary)											Primary Care Physician Name*		Seen in last 12 mo or current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Applicants	Circle One	Last Name	First Name	MI	Gender M/F	*Rel. Code	Last Name	First Name	Physician Code (10 digit NPI number)	Physician City			
Applicant	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dep. 1	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dep. 2	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dep. 3	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Relationship Code			Type of Application:		
N - Child (By Birth or Adoption)	P - Principal Support*	C - Court Order Coverage (QMCSO)**	<input type="checkbox"/> New application		
S - Stepchild	A - Child Adoption in Process**	D - Disabled Child (Pa 275)***	<input type="checkbox"/> Add spouse/dependents to current contract # _____		
* Attached legal documentation	L - Legal Guardianship**	*** Attached Physician Statement	<input type="checkbox"/> Delete spouse/dependents from current contract # _____		
	** Attached Court Order		<input type="checkbox"/> Address change provide address above		
			Effective date of change _____		
			Subscriber signature _____		

**Part II: Eligibility Information**

1. Do all individuals listed live in Michigan nine months or more each year?  Yes  No

2. Are any individuals listed above:

Eligible for Medicare or Medicaid?  Yes  No If Yes, please provide name: \_\_\_\_\_

Eligible for employer-sponsored health plan?  Yes  No If yes, provide name of applicant and employer name: \_\_\_\_\_

Enrolled in an employer-sponsored health plan through the applicant's or spouse's employer?  Yes  No If yes, please provide the following information: Name of applicant \_\_\_\_\_

Name of employer: \_\_\_\_\_ Name of carrier: \_\_\_\_\_ Contract number: \_\_\_\_\_ Date the coverage will terminate: \_\_\_\_\_

3. Under this individual health plan for which you are applying will your employer or your spouse's employer pay for or reimburse you for any portion of the premium?  Yes  No

**For BCN use Only**

MA Code	Agent Number	Assoc./Chamber Code	Contract Number	Service Code	Eff. Date
			U/W	Preex Date	DEID

# **INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDIVIDUAL COVERAGE ENROLLMENT FORM**

*ALL SECTIONS MUST BE COMPLETED*

## **Part I: Applicant Information**

- The address should include apartment number if applicable. A P.O. Box may not be used.
- List all persons that you wish to cover (including yourself) and identify their relationship to you (e.g., Child, Stepchild).
- In divorce/paternity cases, include appropriate Relationship Code. Legal documentation must be attached (e.g., divorce decree, custodial decree).
- Indicate the name of a BCN primary care physician selected for each person listed. In addition, include physician code (10-digit NPI number), provider location (street and city), whether or not seen by the chosen PCP within last 12 months or a current patient.
- Applicants may locate a primary care physician or the NPI# of their PCP online at MiBCN.com or by calling their customer service representative at 800-662-6667
- Please indicate if this is a new application or a change to an existing contract (add or remove a dependent, or change of address). If adding or removing dependents please provide their information in Part 1.

## **Part II: Eligibility Information**

- If any person listed has other medical insurance coverage either through an employer or on an individual basis, indicate the person covered and complete the requested information.

## **Part III: Health Questionnaire**

- All questions in Section I, II and III must be answered or the applicant may be returned or rejected.

## **Part IV: Terms and Conditions for Coverage**

- Read the terms and conditions for coverage. Sign and date the form before submitting it to the address below.

### **Return completed enrollment form to:**

Audit Specialist – C411  
Blue Care Network of Michigan  
P. O. Box 5043  
Southfield, MI 48086-9929  
Fax: 1-877-218-1466

Customer Service Inquiries 800-662-6667  
TTY for the hearing impaired: 800-257-9980  
8 a.m. to 5 p.m. Monday through Friday

### Part III: Health Questionnaire

INSTRUCTIONS: Please print clearly and answer ALL questions.

APPLICANT NAME		LAST FIRST	MIDDLE		
HOME PHONE (    )	WORK PHONE (    )	MOBILE PHONE (    )		BIRTH DATE ▶	MONTH    DAY    YEAR -       -       -
SOCIAL SECURITY NUMBER ▶    -    -		MARITAL STATUS ▶ <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED			
ADDRESS		NUMBER & STREET			
CITY		STATE		ZIP CODE	

**List all persons to be covered. Attach additional sheets if necessary.**

MEMBER LETTER	FULL NAME	SEX	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	HEIGHT	WEIGHT	SOCIAL SECURITY NO. (Must include for all members 1 year of age and older.)
A			APPLICANT				
B			SPOUSE				
C							
D							
E							
F							
G							
H							
I							

## Section I

All questions must be answered YES or NO or the application may be returned or rejected. If you answer "yes" to any questions, please provide details in Section II.

In the last 5 years, has any person listed on this application been advised, counseled, tested, diagnosed, treated, hospitalized, taken any medication for, or had treatment recommended for any of the following conditions?

A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines; headaches; seizure disorder; epilepsy; Multiple Sclerosis; paralysis, Restless Leg Syndrome; any neurological disorder; or any disorder of the central nervous system?
B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory loss; dementia; narcolepsy; Alzheimer's Disease?
C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attention deficit disorder; anxiety; depression or chemical imbalance; any emotional, behavioral or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy, marital or any other form of counseling or therapy?
D	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain; arrhythmia or palpitations; heart murmur; mitral valve prolapse; heart attack; bypass or angioplasty/stent; stroke or TIA; any other heart or circulatory disorder or condition; hypertension/high blood pressure? If yes to HBP give last three readings & dates: _____
E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elevated cholesterol or lipids; varicose veins; varicosities; anemia; blood clot; any other blood disorder?
F	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma; allergies; sinusitis; bronchitis; pneumonia; RSV; tuberculosis; sleep apnea; chronic obstructive pulmonary disease (COPD); emphysema; any breathing difficulty, lung or respiratory disease, disorder or condition?
G	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux disease (GERD); any disorder of the esophagus; ulcer of the stomach; diverticular disease or any other digestive disorder or condition?
H	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? If yes to hepatitis, indicate type: _____
I	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? If yes indicate diagnosis and location: _____
J	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acne; keratosis; psoriasis; basal cell carcinoma; skin lesions; eczema or any other skin disorder?
K	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney stones; kidney reflux; urinary incontinence; any infection or disorder of the urinary tract, bladder or kidney?
L	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants; any other disease or disorder of the breast?
M	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis (osteo, rheumatoid or psoriatic); bursitis; herniated, bulging or slipped disk; gout, TMJ; any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles or joints; bunions; carpal tunnel syndrome; joint replacement; manipulation or subluxation therapy; spinal fusion?
N	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes; thyroid disorder; goiter; Graves Disease; lupus; pituitary or adrenal disorder?
O	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cataracts; glaucoma; hearing loss; deviated nasal septum; any other eye, ear, nose or throat disorder?
P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS, ARC or HIV positive; any other immune disorder?
Q	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MALES ONLY: Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility; any other disease or disorder of the genital or reproductive system?
R	<input type="checkbox"/> Yes	<input type="checkbox"/> No	FEMALES ONLY: Fibroid or uterine tumor; ovarian cyst; polycystic ovary syndrome (PCOS); endometriosis; cystocele/rectocele; infertility; sexually transmitted disease; genital warts; herpes; abnormal pap smear; any other disease or disorder of the genital or reproductive system?
S	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol use or abuse; alcoholism; substance abuse; drug addiction?
T	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is any person applying for coverage now pregnant or an expectant parent?
U	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever had an implant, internal fixation (pins, screws or plates), prosthesis, pacemaker, valve replacement, shunt or monitoring device?
V	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage had a physical examination (including check ups), diagnostic tests, consulted a physician, chiropractor or therapist? For each person applying for coverage, please provide details of their last physical in <b>Section III</b> .
W	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy or surgery which has not yet been performed?
X	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever been hospitalized or treated in the emergency room, or had any physical impairment, deformity, congenital anomaly, sickness, operation or injury other than those listed above?

In the last five years has any person applying for coverage been prescribed any medication(s)?  Yes  No  
 If yes, please provide details below:

Family Member	Medication & Dosage	Illness for which medication is prescribed	Date prescribed	Date discontinued

**Section II** If you answered “yes” to any of the medical questions in **Section I**, please provide details (attach additional sheet if necessary):

Letter of Question	Family Member	Illness/condition	Date illness began	Date of recovery (if applicable)	Complete recovery? Yes/No	Type of treatment	Name, address & phone of doctor(s) and hospital(s)

**Section III** Details about each family member’s last physical exam:

Family Member	Date of last physical exam	Tests which were done	Test results

**Section IV:** Additional information

<p>Have you ever been or are you now a member of Blue Care Network or Blue Cross Blue Shield of Michigan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date of Coverage _____ and Contract Number _____</p> <p>Has anyone applying for coverage used tobacco products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                  If Yes, who? _____ Date last used tobacco: _____</p>
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**Note:** You may be asked to complete and have your primary care physician sign a Smoking Status Form. We will mail it to you. If you answered “no”, you may be required to take a nicotine screening.

#### **Part IV: Terms and Conditions for Coverage**

- I understand that approval of this application and coverage effective date may be determined by BCN and shall be subject to requirements by BCN for additional information and payment of bills.
- I understand that I am applying for myself and eligible members of my family for health coverage in the individual health plan offered by Blue Care Network of Michigan (BCN). The coverage shall not exceed those benefits and services contained on the certificates and riders.
- I may enroll my legal spouse and eligible dependents who reside in Blue Care Network's service area. Eligible dependents are defined as children of mine or my spouse, by birth, legal adoption, foster parenthood, or legal guardianship. Eligible dependents must be 19 years of age or younger, financially dependent upon me, or are a part of my household. I may not enroll myself, my spouse or any dependents who are eligible for, beneficiaries of, or recipients of Medicare or Medicaid or who are eligible for any employer sponsored health benefit plan.
- I understand that coverage for my dependent child(ren) will end on the December 31 after they reach 19 years of age. These dependent child(ren) may apply for their own One Blue coverage.
- On behalf of myself and my enrolled family members, I agree that all our medical services must be performed, prescribed, directed or authorized by our designated BCN primary care physician(s) except in the case of an immediate and unforeseen medical emergency as those terms are defined in the coverage documents.
- I request that payment of insurance company or HMO benefits be made payable to Blue Care Network of Michigan on my behalf for any services furnished to me by Blue Care Network.
- With regard to costs of hospital and medical services delivered by or paid for by BCN, I agree to assign to BCN, my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts whether by redemption award or voluntary payment or otherwise.
- I understand that the benefits my enrolled family members and I will be eligible for are described in the applicable Certificate and that Blue Care Network's marketing materials are only a summary.
- I understand that I may protest a proposed amendment in this contract or rate changed within 30 days of receipt of notice, and that my continued payment while an appeal is in progress shall not be deemed to constitute acceptance of the proposed amendment or rate change.
- I understand that I may cancel this contract within 72 hours of signing this form. If I or any eligible members of my family incur any claims during this 72 hour timeframe, I will be responsible for payment of these claims. BCN will have no liability.

#### ***Pre-Existing Conditions***

- I understand that during the six month period following the effective date, my enrolled family members and I will not be covered for any and all conditions for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before my enrollment. The terms "conditions" includes, but is not limited to, maternity care, obstetrical care, and termination of pregnancy. I understand that my enrollment date begins on the effective date of coverage as determined by Blue Care Network.
- I understand that acceptance of my application will be subject to medical underwriting.

#### ***Authorization for Use and Disclosure of Protected Health Information (PHI)***

- I understand that Blue Care Network of Michigan may collect personal and Protected Health Information (PHI) about me in order to complete my application for coverage. BCN will use and disclose this information only in accordance with their Notice Of Privacy Practices which is available on MiBCN.com or by calling 313-225-9000.

#### **I authorize:**

- Use and disclosure of my PHI including membership, eligibility and claims data stored on Blue Care Network of Michigan, Blue Cross Blue Shield of Michigan and its subsidiaries' or affiliates' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medication prescribed and other PHI as requested to BCN.

**My authorizations include disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.**

This authorization includes and applies to any and all protected health information related to treatment or services where I have requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

This PHI is to be disclosed so that BCN may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (3) for other legally permissible purposes, including but not limited to, health care operations. If PHI is disclosed under your authorization to persons or organizations that are not subject to federal privacy laws, it may be redisclosed and no longer protected.

I understand that my enrollment with BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCN and from any of the parties listed above to BCN. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months from the signature date. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at MiBCN.com or by contacting my agent. I understand that revocation will not affect actions taken before BCN or any of the parties identified above receive my request.

I certify that the above information is true, correct, and complete to the best of my knowledge. I authorize Blue Care Network to obtain any and all records from providers of service, including but not limited to, records regarding the above conditions, treatment, surgeries, tests, prescriptions, and other information that BCN deems necessary. I understand that the information will be used in reviewing my application and administering coverage and that my failure to provide complete and accurate answers or my submission of false or misleading information may result in voiding of coverage for myself, denial of claims or cancellation of coverage.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT'S SPOUSE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DEPENDENT AGE 18 OR OLDER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
AGENT NAME

\_\_\_\_\_  
AGENT NUMBER

\_\_\_\_\_  
MA/GA NAME

\_\_\_\_\_  
MA/GA NUMBER

\_\_\_\_\_  
AGENT SIGNATURE

\_\_\_\_\_  
DATE

## Authorization Agreement for Automatic Payments

This form may be used for your first payment and for ongoing payments.

Applicant name:		Applicant address:		
City:	State:	Zip code:	Applicant telephone number:	
<b>Authorization for automatic payments</b>				
I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my checking/savings account amounts necessary to pay the premium owed by me under my BCN contract. This authority will remain in effect until I notify you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.				
Bank name:		Branch:		
City:	State:	Zip code:		
Please deduct my monthly BCN premium from (check one):				
<input type="checkbox"/> Checking account (Please include a voided check when you return this form.)				
<input type="checkbox"/> Savings account (Please include a voided deposit slip when you return this form.)				
If you bank online, please write in your checking or savings account number and bank routing number.				
Account number _____				
Bank routing number _____				
Signature:			Date:	

Withdrawals will occur each month on the date your premium payment is due. We will send you written notification of the date your automatic payments begin.

<b>Blue Care Network use only</b>		
Member's contract number:	Process date:	Effective date:
Processor:		