2024 Membership Changes

Individual and Family Plans

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

Use this form to update your information, change your current plan because of a qualifying life event, or terminate coverage.

If you enrolled in your plan through the Health Insurance Marketplace (your enrollee ID starts with XYE), you must contact them directly at 1-800-318-2596 to report all membership changes.

A qualifying life event – **listed below in Section D** – allows you to make changes to your current coverage, generally, within 60 days of the event. To complete your change request, some events require documentation to confirm the event. If you have any questions, please call the Customer Service number on the back of your ID card.

A Enrollee information

First Name ________________ **Last Name** ________________ **M.I.** _____

Enrollee ID *(number on your card beginning with XYG)* ________________

B Apply changes to *(check plan(s) to be affected and fill out group number from each card)*

Medical ____________ **Dental** ____________ **Vision** ____________

C Enrollee changes *(check and fill out all that apply)*

Enrollee Name change **First** ____________ **Last** ____________ **M.I.** _____

Date of birth change *(MM/DD/YYYY)* ____________

Residential address change

A residential address change may result in a change in premium rates. A change of address requires a copy of proof of residency *(driver's license, rental lease, or mortgage agreement)*

Address ________________

City ________________ **State** ________ **ZIP** ________

Alternate mailing address *(an alternate address is for routing of mail only)*

Address ________________

City ________________ **State** ________ **ZIP** ________

Telephone number change

Home ________________ **Cell** ________________

D Qualifying life event *(check event below and fill out all information for the dependent(s) you are adding or removing)*

When submitting completed form, be sure to attach copies of the required documentation for the checked life event. Refer to **bcbsm.com/documents** *for full list of acceptable documentation.* **Date of event** *(MM/DD/YYYY)* ____________

- **Marriage** *(marriage license required)*
- **Birth** *(birth certificate or verification of birth required)*
- **Adoption** *(legal guardianship, foster parenthood, adoption or placement for adoption documentation required)*
- **Loss of coverage** *(prior coverage documentation required)*
- **Death** *(copy of death certificate is required)*
- **Divorce** *(divorce decree or legal separation documentation required)*
- **Enrolled in Medicare** *(proof of coverage with effective date required)*
- **Other** ________________

Dependent information *(only dependent(s) you are adding or removing)*

ADD Dependent **REMOVE Dependent**

First Name ________________ **Last Name** ________________ **M.I.** _____

Date of birth *(MM/DD/YYYY)* ____________ **Social Security Number** ____________

Relation to subscriber ____________ **Gender** *(M/F)* ______ **Tobacco user* Required** *(yes or no)* ______

ADD Dependent **REMOVE Dependent**

First Name ________________ **Last Name** ________________ **M.I.** _____

Date of birth *(MM/DD/YYYY)* ____________ **Social Security Number** ____________

Relation to subscriber ____________ **Gender** *(M/F)* ______ **Tobacco user* Required** *(yes or no)* ______

ADD Dependent **REMOVE Dependent**

First Name ________________ **Last Name** ________________ **M.I.** _____

Date of birth *(MM/DD/YYYY)* ____________ **Social Security Number** ____________

Relation to subscriber ____________ **Gender** *(M/F)* ______ **Tobacco user* Required** *(yes or no)* ______

During the past six months, has the new dependent age 21 and older been a regular tobacco use (four or more times per week excluding religious or ceremonial use)?* ***Blue Cross reserves the right to verify tobacco use and to adjust your premium accordingly.* *Please see Terms and Conditions for additional information at* ***bcbsm.com***.

***By signing this change of status form, if you have dependents under the age of 19, you attest to being compliant with ACA and Essential Health Benefits requirements by having purchased a certified Pediatric Dental plan either with BCBSM or with another insurance carrier.*

Form continues on page 2

E 2024 Medical plan *(check one below)*

Coverage varies by plan type: go to ***bcbsm.com*** *to learn more.*

KEEP CURRENT PLAN
Blue Cross® Premier PPO **Gold**
Blue Cross® Premier PPO **Gold Extra**
Blue Cross® Premier PPO **Silver Extra**
Blue Cross® Premier PPO **Silver**
Blue Cross® Premier PPO **Silver Saver**
add **HSA***
Blue Cross® Premier PPO **Silver Off Marketplace**
Blue Cross® Premier PPO **Bronze Extra**
Blue Cross® Premier PPO **Bronze**
add **HSA***
Blue Cross® Premier PPO **Bronze Secure**
Blue Cross® Premier PPO **Value** *(you must be 29 or younger when coverage begins)*

Health savings account (or HSA) provided by HealthEquity®. There is no charge per month for our HSA. To learn more,* ***visit bcbsm.com/hsa*

F 2024 Blue Dental℠/Vision plan *(check one below)*

Blue Dental℠ Plan is available to all ages; benefits cover all ages with the exception of PPO pediatric, as noted below. Coverage varies by plan type: go to ***bcbsm.com*** *to learn more. If you have a medical plan through Blue Care Network, submit a separate form for your BCN coverage.* ***Exclusive Provider Organization (or EPO)*** *includes all counties except Keweenaw.*

KEEP CURRENT PLAN
PPO **100/70/50 (80/60/50) with** Vision
PPO **100/70/50 (80/60/50)**
PPO Plus **80/60/50 with** Vision
PPO Plus **80/60/50**
PPO **80/50/50 (50/50/50) with** Vision
PPO **80/50/50 (50/50/50)**
PPO Pediatric* **80/50/50 (50/50/50)**
PPO 100/50/50 (50/50/50) with Vision
PPO 100/50/50 (50/50/50)
EPO **80/50/50 (0/0/0) with** Vision
EPO **80/50/50 (0/0/0)**
Vision Glasses or Contacts for Adults - Monthly Billing
Vision Glasses or Contacts for Adults - Annual Billing
Vision Glasses and Contacts for Adults - Monthly Billing
Vision Glasses and Contacts for Adults - Annual Billing

**Benefits only cover members through the end of the year they turn 19.*

G Voluntary contract termination *(includes enrollee and all dependents)*

Please terminate this contract. *(for plan(s) selected in section A) Termination date will be effective as of the receipt of this request, unless you specify a future termination date.*

Requested date ____________________

H Authorization and signature (required)

I understand the summary of benefits and coverage related to the coverage change requested is available at ***bcbsm.com/sbc****. I understand the summary of benefits and coverage is not a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the summary of benefits and my applicable plan document (including certificates and riders), the plan document will control.*

I consent to delivery of the summary of benefits and coverage electronically on the website. I understand a paper copy is also available, free of charge, by calling Blue Cross Blue Shield of Michigan toll-free at 1-888-288-2738. I verify that the qualifying life event information provided on this form is true and correct to the best of my knowledge.

Blue Cross reserves the right to require additional documentation as proof of the event.

Signature of subscriber

SIGN HERE ________________________________ **Date** ____________________

IMPORTANT: Please read the form over carefully and be sure you have:
— Included all necessary information
— Attached copies of required documentation as specified in Sections C and D

Mail this form along with required supporting documentation to:
Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48226-0407
or fax to: **1-866-392-7528**

DO NOT include premium payments.
Premium payments cannot be processed at this address.

SECTION C required documentation
A change of address requires proof of residency
(driver's license, rental lease or mortgage agreement)

SECTION D required documentation
- **Marriage** *(marriage license)*
- **Birth** *(birth certificate or verification of birth)*
- **Adoption** *(legal guardianship, foster parenthood, adoption or placement for adoption documentation)*
- **Death** *(copy of death certificate)*
- **Divorce** *(divorce decree or legal separation documentation)*
- **Enrolls in Medicare** *(proof of coverage with effective date)*

Internal use only *(Agent or Health Plan Advisor)*

As the Blue Cross Blue Shield of Michigan and Blue Care Network appointed Agent of Record for the above member and his or her corresponding policy, or as a Blue Cross Blue Shield of Michigan and Blue Care Network certified Health Plan Advisor, I hereby acknowledge and confirm that the member listed above has granted me the authority to transact the changes or actions indicated on this form. I have made the member aware of all potential impacts to rates, benefits, and eligibility that may result from these changes. I verify that the information provided on this form is true and correct to the best of my knowledge.

Agent/HPA Name ____________________ **Blue Cross 5 Digit Agent ID** ____________________

Agent/HPA Signature

SIGN HERE ________________________________ **Date** ____________________

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܩܐ ܗܝܪܬܘܟܘܢ، ܣܢܝܩܝ ܝܢܘܟܘܢ ܗܝܪܬܐ، ܐܝܬܠܘܟܘܢ ܐܦܫܪܘܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܛܝܡܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܚܕܡܬܐ ܕܥܡܝܠܐ ܥܠ ܣܛܪܐ ܕܟܪܛܝܣܘܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܗܕܡܐ ܠܝܬܘܟܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.