New Subscriber Enrollment

For BCN, or Physician Choice PPO, also complete page 4, Primary Care Provider Selection form

■ Blue Cross Blue Shield of Michigan	
Blue Cross group number 007000391	Division

Employer representative signature SIGN

☐ Blue Care Network		
BCN group number	Subgroup number	Class number

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A. Subscriber information

☐ Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status ☐ S ☐ M	Gender/Sex ☐ F ☐ M

Subscriber birth date	Home street address	City	State	ZIP code

County	Country - if other than USA	Primary telephone number ☐ Home ☐ Work ☐ Cell	Secondary telephone number ☐ Home ☐ Work ☐ Cell	Email

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	**Legal first name**	**M.I.**	**Gender/Sex**	**Birth date**	**Non-U.S. citizen**	**Social Security/TIN number** (required)	**Relationship** (see instructions for codes)
Spouse				☐ F ☐ M		☐		
Dep. 1				☐ F ☐ M		☐		
Dep. 2				☐ F ☐ M		☐		
Dep. 3				☐ F ☐ M		☐		
Dep. 4				☐ F ☐ M		☐		

If the permanent address of the spouse or dependent is different from the subscriber address above, please complete the information below:

Spouse or dependent (full name)	Street address	City	State	ZIP code

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No
If yes, complete this section.

Person covered (full name)		☐ Check if this applies to all members on this contract	
Employer or group name	Policy number	Insurer	Original effective date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No If yes, check category: ☐ Over 65 and working ☐ Retiree ☐ Disabled ☐ ESRD Medicare ID ____________

☐ Medicare primary ☐ Blue Cross or BCN primary	☐ Subscriber ☐ Spouse ☐ Dependent: ____________	Medicare A effective date	Medicare B effective date	Medicare D effective date

I have read and understand the conditions of this form Subscriber signature SIGN Date

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See page 1 instructions for product codes.

Select account option: ☐ HRA ☐ HSA ☐ FSA FSA goal amount ____________ ☐ Opt out Blue Cross product indicator code:

E. Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Hire date	Effective date
GRAND BLANC COMMUNITY SCHOOLS						01/01/2025

Check coverage if applicable:
■ Medical
☐ Vision
☐ Dental
☐ Pharmacy

Check enrollment type: ■ Open enrollment ☐ New hire ☐ Rehire ☐ Return from layoff ☐ Surviving spouse ☐ Retiree

☐ Salary ☐ Hourly

☐ Loss of eligibility (prior coverage) Insurer's name (including Blue Cross & BCN) ____________ Policy number ____________
Contract holder ____________ Termination date ____________

☐ Full time
☐ Part time

☐ COBRA (36 mos.) Check reason: ☐ Termination ☐ Layoff ☐ Reduction of hours ☐ Deceased subscriber ☐ Divorce or legal separation ☐ Loss of dependent status

Previous contract number | Original qualifying date

ECoS Forms — Instructions

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

New Subscriber Enrollment, Change of Status, or Primary Care Provider Selection

1 Select the appropriate forms

This packet includes three forms. See below to determine which form you should use.

New Subscriber Enrollment (page 3):

Use this form to enroll a subscriber in a new plan:

- During **open enrollment**
- As a **new hire**
- When **returning from layoff** or **rehired**
- Because subscriber has **lost eligibility** on another plan (loss of coverage). *If coverage is lost from an insurance carrier other than Blue Cross or BCN, a letter of credible coverage is required.*
- As a **retiree**
- When **surviving spouse** is eligible for enrollment as a new subscriber
- When a **spouse or dependent is enrolling in COBRA** as a new subscriber

Change of Status (page 5):

Use this form to make changes to an existing plan, such as:

- **Adding a dependen**t, including a spouse or child
- **Removing a dependent**, including a spouse or child
- **Transferring subscriber to a new division/ subgroup**
- **Changing or correcting personal information**, such as name, address, email or phone number.
- **Transferring an existing subscriber to a COBRA plan**

Primary Care Provider Selection (page 4)

Complete this form if:

- Subscriber is **enrolling in a BCN HMO plan or the Physicians Choice PPO plan**
- Subscriber, spouse or dependent is **changing PCP** — this can also be done conveniently online or in the Blue Cross app

2 Note the codes and documentation you will need

Use the codes below to complete sections B and D of the New Subscriber Enrollment or Change of Status forms.

Section B. Dependent information

Use codes below to indicate relationship.

Spouse **SP**
Domestic Partner* **DP**
Child *(by birth or adoption)* **N**
Stepchild **S**
Child adoption in process** **A**
Legal Guardianship** **L**
Disabled child*** **D**
Sponsored dependent* **SD**
Foster child **FC**
Court Order Coverage (QMCSO)** **C**

**Attach documentation*
***Attach court order*
****Attach provider statement*

Section C. Other health care coverage

Members with other health care coverage can contact insurer to find the original effective date.

If any members are enrolled in Medicare, please attach a copy of the Medicare card.

Section D. Health savings, health reimbursement and flexible spending account options

Do not complete for Blue Care Network members. If the plan offers HSA, HRA or FSA accounts and you are enrolling in one, use the codes below to indicate the account type you have selected.

HSA only **1000**
- HSA with limited purpose FSA **1070**
- HSA with dependent care FSA **1004**
- HSA with limited purpose FSA & dependent care FSA **1074**
- HSA with limited purpose HRA **1600**
- HSA Opt Out - High deductible plan without HSA **0000**

HRA only **0100**
- HRA with limited purpose FSA **0170**
- HRA with dependent care FSA **0104**
- HRA with limited purpose FSA & dependent care FSA **0174**
- HRA with health care FSA **0110**
- HRA with health care FSA & dependent care FSA **0114**

Health care FSA **0010**
- Dependent care FSA **0004**
- Health care and dependent care FSA **0014**
- PPO without Health care FSA **0000**

Section E. Employer/Group use only

New subscriber enrollment/COBRA: For a spouse or dependent applying to be the subscriber on a COBRA plan, the duration is always 36 months. **Change of status/COBRA:** For an existing subscriber changing to a COBRA plan, where the qualifying event is termination, COBRA duration is 18 months. In certain circumstances, if a disabled subscriber and non-disabled family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA coverage, for a total of 29 months.

3 Complete the forms and send to Membership and Billing

Be sure that:

- **Employer representative** has signed New Enrollment or Change of Status form.
- **Subscriber** has read the contract conditions on page 2 and signed where indicated on each form.
- **All required documentation is attached.**

For Blue Cross Blue Shield of Michigan

Mail:
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610I
P.O. Box 2260
Detroit, MI 48226

Fax:
1-866-900-2619

For Blue Care Network

Mail:
Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086

Fax:
1-877-218-1466