

Change of Status

Use this form to change personal information, add or delete a member, transfer division or transfer an existing subscriber to COBRA.

<input checked="" type="checkbox"/> Blue Cross Blue Shield of Michigan	
Blue Cross group number 007000391	Division

<input type="checkbox"/> Blue Care Network		
BCN group number	Subgroup number	Class Number



Employer representative signature **SIGN**

Date

A. Subscriber information — Fill in the fields marked with an asterisk only if the information has changed

<input type="checkbox"/> Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Marital status* <input type="checkbox"/> S <input type="checkbox"/> M	Gender/Sex* <input type="checkbox"/> F <input type="checkbox"/> M
Subscriber birth date	New home street address*	City*		State*	ZIP code*	
County*	Country* - if other than USA	Primary telephone #* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary telephone #* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> 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 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 3 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		
Dep. 4 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>		

If the permanent address of the spouse or dependent is different from the subscriber address above, please provide here:	Spouse or dependent (full name)	Home address	City	State	ZIP code
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C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete this section.	Person covered (full name)	<input type="checkbox"/> 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 _____

<input type="checkbox"/> Medicare primary	<input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse	Medicare A effective date	Medicare B effective date	Medicare D effective date
<input type="checkbox"/> Blue Cross or BCN primary	<input type="checkbox"/> Dependent: _____			

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 instructions for product selection codes

<input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> FSA FSA goal amount _____ <input type="checkbox"/> Opt out	Blue Cross product indicator code: _____	<input type="checkbox"/> Add/Change <input type="checkbox"/> Cancel
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E. Employer/Group use only

Group name GRAND BLANC COMMUNITY SCHOOLS	Employer Reference ID	Department ID	Benefit code	Plan code
Type of change: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Add member <input type="checkbox"/> Benefit change <input type="checkbox"/> Transfer: new division/subgroup _____ <input type="checkbox"/> Subscriber COBRA enrollment: <input type="checkbox"/> 18 <input type="checkbox"/> 29 mos.		Event date	Cancellation: check type <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Loss of eligibility (prior coverage): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below Insurer (including Blue Cross & BCN) _____ Policy number _____ Contract holder _____ Termination date _____		Effective date	Check reason: <input type="checkbox"/> Left employment <input type="checkbox"/> Retired <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other insurance <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other	
			Last date of coverage _____	

ECoS Forms — Instructions

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



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

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 dependent**, 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 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.

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**

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. 6101
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