Blue Cross Blue Shield Blue Care Network of Michigan

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

SUBSCRIBER NEW ENROLLMENT

(see Page 3 for instructions) ☐ BCBSM ☐ BCN Members - Complete Page 4 for PCP Selection

BCBSM group number	Division	BCN group ID	Subgroup	Class ID	Employer representative signature

Subscriber information

Date	Social Security number (required)	Subscriber last name	Subscriber first name	M.I.	Marital status ☐ S ☐ M	Gender ☐ M ☐ F

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	E-mail

List all persons to be covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*Relationship code (see instructions for codes)
Spouse				☐M ☐F			
Dep. 1				☐M ☐F			
Dep. 2				☐M ☐F			
Dep. 3				☐M ☐F			
Dep. 4				☐M ☐F			

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

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

Coordination of benefits information

Do you, your spouse dependents maintain other coverage? ☐ Yes ☐ No If Yes, complete below: ☐ Check here if this applies to all members on the contract:

Person covered (full name)	Employer or group name	Policy number	Carrier	Address

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

Health savings and flexible spending account options

☐ HSA ☐ HSA Opt out ☐ BCBSM Product indicator code: ☐ Add ☐ Change ☐ Cancel ☐ FSAMED Goal amount: ☐ FSADEPCA Goal amount:

Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date

Check coverge if applicable: ☐ Medical ☐ Vision ☐ Dental

Check type of enrollment: ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Salary ☐ New ☐ Full time ☐ Rehire ☐ Part time ☐ Retiree ☐ Surviving spouse ☐ Hourly ☐ Open enrollment

Old group division/subgroup _____

New group division/subgroup _____

Average hours worked per week (required): _____

Job title (required): _____

COBRA enrollment Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Loss of dependent status ☐ Deceased subscriber

Previous contract number

Original qualifying date

Loss of eligibility (prior coverage) ☐ Yes ☐ No If Yes, complete:

Carrier's name(Including BCBSM and BCN)	Contract holder name	Policy number	Termination date

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD

HIC number:

☐ Medicare primary ☐ BCBSM or BCN primary	Medicare A effective date	Medicare B effective date	Medicare Part D effective date

Blue Cross Blue Shield Blue Care Network of Michigan

BCN Primary Care Physician Selection (see Page 5 for instruction)

Subscriber Social Security number (required for age 45 and older)	BCN group number	Subgroup number	Class number

If you are enrolling in BCN, you need to select a primary care physician for you and each person on your contract. List your selection(s) on this form. You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a PCP. You also need to fill out this form if you are already enrolled in BCN and have decided to change your PCP.

Need information about available primary care physicians?
Our website **BCBSM.com/find-a-doctor** provides the most current information on BCN-affiliated primary care physicians. You can search for a doctor by family practice, general medicine, internal medicine, internal medicine and pediatrics, pediatrics and preventive medicine, city or hospital group.

Member Information

	Member's last name, first name	Physician last name, first name	Physician's NPI#	Physician address	If changing PCPs, list reason	Seen in the last 12 months?
Subscriber						☐Yes ☐No
Spouse						☐Yes ☐No
Dep. 1						☐Yes ☐No
Dep. 2						☐Yes ☐No
Dep. 3						☐Yes ☐No
Dep. 4						☐Yes ☐No

Group/Employer's name:	Date you changed to this physician:
I have read and understand the conditions of this form. Subscriber signature:	Date:

Return this form to start your health care partnership
We encourage you to return this form as soon as you enroll so we can notify your doctor of your membership.

Fax your completed form to 1-877-218-1466.
Or, mail to:
Membership and Billing
Mail Code C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

All changes become effective two business days after we receive this form — unless you request a later effective date.
You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while you are being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs.

You may request to change your PCP effective immediately by calling the Physician Selection Line at **800-662-6667.**
TTY users call 1-800-257-9980.