



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

# ENROLLMENT/ CHANGE OF STATUS

**SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4**

Subscriber Social Security: \_\_\_\_\_ Subscriber Last Name: \_\_\_\_\_  check if new

Home Street Address: \_\_\_\_\_  check if new City: \_\_\_\_\_ State: \_\_\_\_\_ Area Code/Home Phone: \_\_\_\_\_

Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Current Marital Status:  Single  Married Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Area Code/Work Phone: \_\_\_\_\_

MI

List all persons to be enrolled / terminated:

Circle One	LAST NAME	FIRST NAME	M I S	DATE OF BIRTH	SOCIAL SECURITY #	PRIMARY CARE PHYSICIAN NAME - BCNU/POS ONLY	PHYSICIAN #	PHYSICIAN LOCATION	See at the 12 months YES NO
1			X						
2									
3									

**SECTION 2**

**\* Relationship Code**

N - Child (by Birth or Adoption) P - Principal Support\* SD - Sponsored Dependent\*  
 S - Stepchild A - Child Adoption in Process\*\* C - Court Order Coverage (OMCSO)\*\*  
 F - Family Continuation 19+ L - Legal Guardianship\*\* D - Disabled Child (PA 275)\*\*

**Previous BCBSM/POS Affiliation** I have previously been enrolled in: (Check applicable box)  
 BCBSM  BCN  POS

Enter contract # \_\_\_\_\_

**PCP Change Reason - BCNU/POS ONLY**

**SECTION 3**

Do you, your spouse or dependent(s) maintain other health coverage?  NO  YES If Yes, complete below:

Person covered (Full name)	Group	Policy Number	Carrier	Location
Person covered (Full name)	Group	Policy Number	Carrier	Location

Are you, your spouse or any dependents listed in section 2 enrolled in Medicare?  No  Yes If Yes, attach a copy of Medicare card(s)  Actively working  Retired  Under 65  ESRD (End Stage Renal Disease)

**Other Coverage**

**SECTION 4**

Subscriber Signature: \_\_\_\_\_ Signature Date: \_\_\_\_\_ Remarks: \_\_\_\_\_

**GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES**

BCSSM Group/Unit or BCN Group I.D./Subgroup I.D. BCSSM Service Code/BCN Class I.D. Employee I.D. Badge # Group Name  
 00107441 - 3200 XXXXXXXX XXXXXX Mercy General Health Partners

**COVERAGE PLAN:** Blue Care Network Plan:  Medical  Rx  Hearing  Vision  Dental  BCSSM Coverage:  Traditional/CNM  POS  PPO  Dental Only  Vision Only

**ENROLLMENT:** Effective Date: \_\_\_\_\_ Date of Hire or Full Time Status: \_\_\_\_\_  New  Part-Time  Hourly  Retire  Open Enrollment  Return to work from Layoff  Address Change

**REASON FOR CHANGE:** Effective Date: \_\_\_\_\_  Marriage  Duplicate ID Card  Name Change  Address Change  
 Dependent(s)  Loss of Coverage (Certificate of Qualitable Coverage Required)  PCP Change  
 FCR/DCCR  Transfer  HIPAA Qualifying Event (describe event): \_\_\_\_\_

**CANCEL COVERAGE:** Last Date of Coverage: \_\_\_\_\_  Contract  COBRA  Dependent Over Age  Left Employment  
 Spouse  Divorce  Death  Other \_\_\_\_\_

**COBRA ENROLLMENT:** Original Qualifying Date: \_\_\_\_\_  Termination  Layoff  Divorce/Legal Separation  Previous Contract # \_\_\_\_\_  
 Reduction of Hours  Deceased Subscriber  Loss of Dependents Status

**MEDICARE STATUS:** Effective Date: \_\_\_\_\_  Medicare Primary per MSP Law(s)  BCSSM/BCN Primary per MSP Law(s)  ESRD (End Stage Renal Disease)

Please attach a copy of Medicare card(s)