Blue Cross Blue Shield Blue Care Network of Michigan

Change of Status

BCBSM BCN Member (see instructions on Page 7)

BCBSM group	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date
	—					/ /

Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status*	Gender
				S M	M F

New home street address*	City*	State*	ZIP code*	E-mail*

County*	Country – if other than USA*	New primary phone* Home Work Cell	New secondary phone* Home Work Cell	* Indicate changes only

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)	Relationship code (See instructions for codes)
Spouse Add Delete				M F	/ /		
Dep. 1 Add Delete				M F	/ /		
Dep. 2 Add Delete				M F	/ /		
Dep. 3 Add Delete				M F	/ /		
Dep. 4 Add Delete				M F	/ /		

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

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

Person covered (full name)	Group name	Policy number	Carrier	Address

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

Flexible spending account arrangements

FSAMED Effective date: / / Goal amount: _____ FSAPARK Effective date: / / Goal amount: _____

FSADEPCA Effective date: / / Goal amount: _____ FSATRANS Effective date: / / Goal amount: _____

Add Change Cancel

Employer/Group use only

Group name	Employe I.D. badge or department #	Benefit code	Plan code

Check reason for change below:

Marriage FC/DCCR Loss of coverage

Dependents Name change

Date of event: / / Effective date: / /

Check type of cancellation and reason below. Type: Contract Spouse Dependents

Reason: COBRA Death Left employment

Divorce Dependent over age Other

Retired Other insurance

Last date of coverage: / /

Loss of prior coverage? Yes No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date
			/ /

Are any listed members enrolled in Medicare? No Yes If Yes, check category Over 65 and working Retired Disabled ESRD

Medicare primary per MSP laws

BCBSM or BCN primary per MSP laws

Medicare A effective date: / / Medicare B effective date: / / Medicare D effective date: / / HIC #: _____