



Change of Status

BCBSM or BCN Member (see instructions on Page 7)

Blue Cross Blue Shield of Michigan

BCBSM group

Division

BCN group number

Subgroup number

Class number

Employer representative signature

Date

Subscriber Social Security number (*Required)

Subscriber last name*

Subscriber first name*

M.I.*

Marital status* S M F

Gender 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

Relationship code (See instructions for codes)

List all persons to be added or deleted:

Spouse	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)	Relationship code (See instructions for codes)
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> 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 Subscriber the conditions of this form. signature:

Date:

Health savings and flexible spending account options

FSAMED Effective date: _____ Goal amount: _____

HSA

Product indicator code

Add Change Cancel

FSADEPCA Effective date: _____ Goal amount: _____

Employer/Group use only

Group name

Employee ID, badge or department #

Benefit code

Plan code

Check reason for change below: Marriage Loss of eligibility (prior coverage) Dependents Name change Open enrollment Date of event: _____ Effective date: _____

Check type of cancellation and reason below. Type: Contract Spouse Dependents Reason: COBRA Death Divorce Dependent over age Left employment Retired Other insurance Other Last date of coverage: _____

Loss of eligibility (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 Medicare A Medicare B BCBSM or BCN primary per MSP laws Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC #: _____