

Instructions for completing Subscriber New Enrollment form on Page 2

- Indicate if enrolling in BCBSM or BCN: If enrolling with BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 to designate your primary care physician.
- Enter BCBSM group and division number (for example, suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the *Employer signature* section.

Subscriber information:

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name and middle initial. Indicate whether single or married, male or female. Enter subscriber date of birth.
- Enter home address beginning with street address, city, state and ZIP code. Enter e-mail address.
- Enter county name for home address, country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if you have more than four dependents.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

- | | | |
|-----------------------------------|----------------------------------|-------------------------------------|
| N - Child (by birth or adoption) | A - Child adoption in process ** | C - Court order coverage (QMCSO) ** |
| S - Stepchild | L - Legal guardianship ** | D - Disabled child *** |
| P - Principal support (BCN only)* | SD - Sponsored dependent * | M - Medicare |

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouses or dependents permanent address if different from the address indicated above.

Coordination of benefits information

- Indicate yes or no if you, your spouse or dependent maintain other health care coverage. If yes, list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Health savings and flexible spending account options:

- Check all applicable options and enter the goal amount. Enter the four digit product indicator code.

FSAMED – Medical spending account	HSA – Health Savings Account
FSADPCCA – Dependent care flexible spending account	HSA – Health Savings Account opt out

Employer/Group use only

- Enter employer or group name and employee identification, badge or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (BCBSM plan servicing this contract). Enter date of hire and effective date.
- Please check all applicable boxes to indicate coverage selected.
- Check type of enrollment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If enrolled in COBRA check the reason for COBRA. Indicate the previous contract number and the original qualifying date.
- For loss of eligibility (prior coverage), indicate Yes or No. If yes, please indicate the carrier name, contract holder name, policy number and termination date.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary per mandatory secondary payer laws, and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Please provide all documentation for enrollment.