New Subscriber Enrollment

For BCN, or Physician Choice PPO, also complete page 4, Primary Care Provider Selection form

☐ Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

☐ Blue Care Network		
BCN group number	Subgroup number	Class number

Employer representative signature SIGN

Blue Cross Blue Shield Blue Care Network of Michigan

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

A. Subscriber information

☐ Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status ☐ S ☐ M	Gender/Sex ☐ F ☐ M

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	Email

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	Legal first name	M.I.	Gender/Sex	Birth date	Non-U.S. citizen	Social Security/TIN number (required)	Relationship (see instructions for codes)
Spouse				☐ F ☐ M		☐		
Dep. 1				☐ F ☐ M		☐		
Dep. 2				☐ F ☐ M		☐		
Dep. 3				☐ F ☐ M		☐		
Dep. 4				☐ F ☐ M		☐		

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

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

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No If yes, complete this section.	Person covered (full name)		☐ Check if this applies to all members on this contract	
	Employer or group name	Policy number	Insurer	Original effective date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No | If yes, check category: ☐ Over 65 and working ☐ Retiree ☐ Disabled ☐ ESRD | Medicare ID _____

☐ Medicare primary ☐ Blue Cross or BCN primary	☐ Subscriber ☐ Spouse ☐ Dependent: _____	Medicare A effective date	Medicare B effective date	Medicare D effective date

I have read and understand the conditions of this form | Subscriber signature SIGN | Date

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See page 1 instructions for product codes.

Select account option: ☐ HRA ☐ HSA ☐ FSA FSA goal amount _____ ☐ Opt out | Blue Cross product indicator code:

E. Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Hire date	Effective date

Check coverage if applicable:
☐ Medical
☐ Vision
☐ Dental
☐ Pharmacy

Check enrollment type: ☐ Open enrollment ☐ New hire ☐ Rehire ☐ Return from layoff ☐ Surviving spouse ☐ Retiree

☐ Salary ☐ Hourly

☐ Loss of eligibility (prior coverage) Insurer's name (including Blue Cross & BCN) _____ Policy number _____

Contract holder _____ Termination date _____

☐ Full time ☐ Part time

☐ COBRA (36 mos.) Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Deceased subscriber ☐ Loss of dependent status

Previous contract number

Original qualifying date