# Enrollment Change of Status Form (ECOS)

**PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE ATTACHED ENROLLMENT CHANGE OF STATUS FORM.**

**THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) OR BLUE CARE NETWORK OF MICHIGAN (BCN).**

I am applying for coverage for myself and my family members identified on this application under my group's or association's contract with BCBSM or BCN (BCBSM/BCN). Coverage begins on the date determined by BCBSM/BCN. When BCBSM/BCN accepts my application, I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility**: I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM/BCN.

**Authorization**: I appoint my group or association to handle all matters of coverage. It may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM/BCN and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM/BCN, and for other purposes necessary for BCBSM/BCN to fulfill its contractual and statutory obligations.

**Release of Information**: I acknowledge that BCBSM/BCN requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM/BCN for purposes of administering our coverage. Upon my request, BCBSM/BCN will tell me where the information was sent.

**COBRA**: I will not be eligible for a waiver of any preexisting exclusion in BCBSM non-group coverage if I do not elect and exhaust any COBRA coverage available to me.

If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer I authorize BCBSM/BCN to provide claims information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

## BLUE CARE NETWORK ONLY

I and my enrolled family members agree that all of our medical services must be performed, prescribed, directed or authorized by our designated BCN Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency when the time needed to contact our Primary Care Physician(s) may mean permanent damage to our health. Unauthorized services that are not an immediate emergency, as described above, received from non-Blue Care Network providers will not be covered.

The BCN service area excludes Branch, Lake, Lenawee, Mason, Missaukee, Osceola and Sanilac counties. Residents of these counties may receive services in a BCN covered county by providing BCN with and Out of Area Waiver at the time of enrollment.

I agree to assign to BCN my entire right of recovery of the cost of hospital, medical and prescription services delivered by or paid for by BCN against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts, whether by redemption award or voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release to the Centers for Medicare and Medicaid Services, any insurance company, or any HMO and their agents any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company, or HMO benefits be made payable to BCN on my behalf for any services furnished to me and my enrolled family members by BCN.

## BLUE CHOICE POINT OF SERVICE ONLY

I and my enrolled family members agree that all our medical services must be performed, prescribed, directed or authorized by our designated POS Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency and the time needed to contact our Primary Care Physician(s) may mean permanent damage to our health. Unauthorized services that are not an immediate and unforeseen emergency, as described above, will be subject to applicable out of network deductibles and copays.

**Send completed form to**:

Blue Cross Blue Shield of Michigan
Membership and Billing – 1704
P.O. Box 2260
Detroit, MI 48231-2260

Blue Care Network
Membership Department – C411
P.O. Box 5043
Southfield, MI 48086

INSTRUCTIONS FOR COMPLETING ENROLLMENT/CHANGE OF STATUS FORM
ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED

## Page 3 – Subscriber Information

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Subscriber Last Name (check box if new), Subscriber First Name, and Middle Initial. If there is not enough spaces to accommodate your full name, print or type full name in the remarks section at the bottom of page 3. Indicate whether single or married, male or female.
- Enter Subscriber date of birth, home phone number (check box if new).
- Enter home address beginning with street address (check box if new), City, State & Zip Code. Enter work phone number (check box if new).
- Enter county name for home address, Country name (if other than USA), email address.
- List all persons to be enrolled/terminated: Enter name(s) on appropriate line – spouse, dependent 1, 2, and 3 as applicable. Complete additional forms if more dependents are to be covered. Check if they are to be added or deleted. Enter last name, first name, middle initial, male or female, date of birth, social security number and rel code (relationship codes are listed below).
- BCN/POS Only - Enter physician last name, first initial, physician number and location for each member (subscriber, spouse, dependent 1, 2, and 3). Check the box if the member has been seen by the designated physician within the last 12 months.
- BCN/POS Only - PCP Change Reason – enter reason for request to change primary care physician. Group representative signature not required. Change can also be made at MiBCN.com., if BCN.
- Previous BCBSM Affiliation – check if previously enrolled in either BCBSM or BCN and enter contract number.
- Permanent Address – Enter the spouse/dependents address if different from the address indicated above.
- Other Health Coverage - Indicate no or yes if you, your spouse or dependent maintain other health care coverage – if yes, complete name of person covered, group name, policy number, carrier name and location. If other health coverage applies to all members on the contract, check the applicable box.
- Indicate if you, your spouse or dependent are enrolled in Medicare – if yes, a copy of your Medical card(s) is required, check off applicable status: actively working, retired, under 65 or ESRD (End State Renal Disease).
- In the signature section, sign your full name, enter the date you signed the form and make any notations in the remarks field.

## Page 4 – Group Use only – check and complete appropriate boxes

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Group name and employee Identification Badge number, if applicable.
- BCBSM Only: Enter BCBSM Service Code (12 digit)), Group Representative Signature and date.
- Indicate if subscriber is enrolling in either BCBSM or Blue Care Network, check all applicable coverage the subscriber is enrolling in even coverage they wish to maintain – medical, dental, vision. If enrolling in BCN and there is a separate group number for your BCBSM dental or vision product, complete two Enrollment Change of Status forms – one with BCBSM Dental/Vision group/suffix number and one with the BCN group, subgroup and class I.D. and submit to the appropriate areas (see bottom on page 1).
- **NEW** Section: check applicable box, enter date of hire and effective date.
- Reason for **CHANGE** section: to change a subscriber/dependent(s) health care coverage check the appropriate box, enter date of event and effective date.
- **CANCEL** Section: check applicable box for contract holder, spouse or dependent, check reason for canceling and enter last date of coverage.
- **COBRA** Section: check reason, enter previous contract number and enter the original qualifying status date.
- **TRANSFER/LOSS OF COVERAGE** Section: if you checked transfer in the new section above, or loss of coverage in the change section above, indicate the carrier's name, contract holder name, policy number and termination date.
- **MEDICARE STATUS** Section: indicate if Medicare is primary or BCBSM/BCN is primary per MSP (Mandatory Secondary Payer) law(s), enter effective date of the Medicare coverage, and attach a copy of the Medicare card(s).

PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT

# ENROLLMENT / CHANGE OF STATUS

| Subscriber SSN (or assigned contract number) | BCBSM Group | Suffix | BCN Group ID | Subgroup ID | Class ID |
|---|---|---|---|---|---|
| - - | - | | | | |

## SUBSCRIBER INFORMATION

| Subscriber Last Name ☐ check if new | Subscriber First Name | M.I. | Marital Status | Gender | Subscriber Birth Date | Home Phone ☐ check if new |
|---|---|---|---|---|---|---|
| | | | ☐ S ☐ M | ☐ M ☐ F | / / | - - |

| Home Street Address ☐ check if new | City | State | Zip Code | Work Phone ☐ check if new |
|---|---|---|---|---|
| | | | | - - |

| County | Country - if other than USA | Email - optional |
|---|---|---|
| | | |

**List all persons to be enrolled / terminated:**

| | CHECK ONE | LAST NAME | FIRST NAME | M I | GENDER | DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY # | * REL CODE |
|---|---|---|---|---|---|---|---|---|
| Spouse | ☐ Add ☐ Delete | | | | | / / | | |
| Dep-1 | ☐ Add ☐ Delete | | | | | / / | | |
| Dep-2 | ☐ Add ☐ Delete | | | | | / / | | |
| Dep-3 | ☐ Add ☐ Delete | | | | | / / | | |

**BCN/POS - PRIMARY CARE PHYSICIAN (PCP)**

| | PHYSICIAN LAST NAME | FIRST INITIAL | PHYSICIAN # | PHYSICIAN LOCATION | Seen in the last 12 months? |
|---|---|---|---|---|---|
| Subscriber | | | | | ☐ Yes |
| Spouse | | | | | ☐ Yes |
| Dep-1 | | | | | ☐ Yes |
| Dep-2 | | | | | ☐ Yes |
| Dep-3 | | | | | ☐ Yes |

*** Relationship Code**

- **N** - Child (by Birth or Adoption)
- **A** - Child Adoption in Process**
- **S** - Stepchild
- **L** - Legal Guardianship**
- **F** - Family Continuation 19+
- **SD** - Sponsored Dependent*
- **P** - Principal Support*
- **C** - Court Order Coverage (QMCSO)**
- **D** - Disabled Child (BCBSM - PA350) (BCN - PA218)***

* = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement

| PCP Change Reason -BCN/POS | Previous BCBSM Affiliation |
|---|---|
| | I have previously been enrolled in: (Check applicable box) ☐ BCBSM ☐ BCN Enter Contract # |

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

| Spouse/Dependent (Full Name) | Street Address | City | State | Zip code |
|---|---|---|---|---|
| | | | | |

Do you, your spouse or dependent(s) maintain other health coverage? ☐ NO ☐ YES If Yes, complete below: Check here if this applies to all members on the contract: ☐

| Person covered (Full Name) | Group Name | Policy Number | Carrier | Location |
|---|---|---|---|---|
| | | | | |
| Person covered (Full Name) | Group Name | Policy Number | Carrier | Location |
| | | | | |

Are you, your spouse or any dependent(s) listed enrolled in Medicare? ☐ NO ☐ YES If Yes, attach a copy of Medicare card(s). ☐ Actively working ☐ Retired ☐ Under 65 ☐ ESRD (End Stage Renal Disease)

**I have read and understand the conditions on page 1 of this form.**

| Subscriber Signature | Signature Date | Remarks |
|---|---|---|
| | | |

Blue Cross Blue Shield Blue Care Network of Michigan

# ENROLLMENT / CHANGE OF STATUS

Subscriber SSN ___ - ___ - ___ BCBSM Group ___ - Suffix ___ BCN Group ID ___ Subgroup ID ___ Class ID ___

## Group Use Only - Check and Complete Appropriate Boxes

Group Name

Employee I.D. Badge #

BCBSM Service Code

Group Representative Signature

Date

**Coverage/Plan:** Check if enrolling in : ☐ BCBSM ☐ Blue Care Network

Check all applicable coverage (including all existing coverage you wish to maintain): ☐ Medical ☐ Dental ☐ Vision

## Enrollment, Reason For Change, Cancel Coverage, COBRA Enrollment, HIPAA Qualifying Events, Medicare Status

**NEW**, Check Type of Enrollment below:

- ☐ New
- ☐ Retiree
- ☐ Rehire
- ☐ Hourly
- ☐ Full Time
- ☐ Salary
- ☐ Part Time
- ☐ Surviving Spouse
- ☐ Transfer
- ☐ Open Enrollment
- ☐ Return to Work from layoff

Date Of Hire __ / __ / ____

Effective Date __ / __ / ____

**CHANGE**, Check applicable change below:

- ☐ Marriage
- ☐ Name Change
- ☐ Dependent(s)
- ☐ Loss of Coverage
- ☐ FCR/DCCR
- ☐ PCP Change

Date of Event __ / __ / ____

Effective Date __ / __ / ____

**CANCEL**, check type of cancellation & reason below:

TYPE: ☐ Contract ☐ Spouse ☐ Dependent(s)

REASON:

- ☐ COBRA
- ☐ Death
- ☐ Divorce
- ☐ Other Insurance
- ☐ Retired
- ☐ Left Employment
- ☐ Dependent Over Age
- ☐ Other ____________

Last Date of Coverage __ / __ / ____

**COBRA** Enrollment, check reason below:

- ☐ Termination
- ☐ Divorce/Legal Separation
- ☐ Layoff
- ☐ Deceased Subscriber
- ☐ Reduction of Hours
- ☐ Loss of Dependent Status

Previous Contract #

Original Qualifying Date __ / __ / ____

If transfer/loss of coverage, complete below:

Carrier's Name

Contract Holder Name

Policy #

Termination Date __ / __ / ____

**Medicare Status**

☐ Medicare Primary per MSP Law(s) ☐ BCBSM/BCN Primary per MSP Law(s)

Effective Date __ / __ / ____

Attach a copy of Medicare card(s)