



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
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Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status* <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F
New home street address*		City*	State*	ZIP code*	E-mail*
County*	Country – if other than USA*	New primary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	New secondary phone* <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> 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 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 1 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 2 <input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> M <input type="checkbox"/> F			
Dep. 3 <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
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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
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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: _____ Add Change Cancel

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

Employer/Group use only

Group name	Employee I.D. badge or department #	Benefit code	Plan code
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Check reason for change below: <input type="checkbox"/> Marriage <input type="checkbox"/> FC/DCCR <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Dependents <input type="checkbox"/> Name change Date of event: _____ Effective date: _____	Check type of cancellation and reason below. Type: <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents Reason: <input type="checkbox"/> COBRA <input type="checkbox"/> Death <input type="checkbox"/> Left employment <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent over age <input type="checkbox"/> Other <input type="checkbox"/> Retired <input type="checkbox"/> Other insurance Last date of coverage: _____
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Loss of prior coverage? Yes No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date
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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 effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____ HIC #: _____

BCBSM or BCN primary per MSP laws