



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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(see Page 3 for instructions)

BCBSM BCN Member - Complete Page for PCP Selection

BCBSM group number	Division	BCN group ID	Subgroup ID	Class ID	Employer representative signature	Date
						/ /

Subscriber information

Social Security number (Required)	Subscriber last name	Subscriber first name	M.I.	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> F	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber birth date
						/ /
Home street address			City	State	ZIP Code	
County	Country - if other than USA	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Primary phone		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Secondary phone		
E-mail - optional						

List all persons to covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*Relationship code (see instructions for codes)
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 1				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 2				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 3				<input type="checkbox"/> M <input type="checkbox"/> F	/ /		
Dep. 4				<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 information below:

Spouse or dependent (full name)	Street address	City	State	ZIP code
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Coordination of benefits information

Do you, your spouse or dependent(s) 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)	Employer or 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 Goal amount: FSADEPCA Goal amount: FSAPARK Goal amount: FSATRANS Goal amount:

Employer/Group use only

Group name:	Employee ID badge #:
Benefit code:	Plan code:
Date of hire: / /	Effective date: / /

Check coverage if applicable (BCBSM only): Dental only Vision only Dental and vision only Other

Check type of enrollment: <input type="checkbox"/> New <input type="checkbox"/> Transfer <input type="checkbox"/> Hourly <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff <input type="checkbox"/> Salary <input type="checkbox"/> Full time <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Part time <input type="checkbox"/> Retiree <input type="checkbox"/> Open enrollment	Average hours worked per week (required): _____ Job title (required): _____	COBRA enrollment <input type="checkbox"/> Termination <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Divorce or legal separation Check reason: <input type="checkbox"/> Layoff <input type="checkbox"/> Loss of dependent status <input type="checkbox"/> Deceased subscriber Previous contract # _____ Original qualifying date: / /
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Loss of prior coverage? Yes No If Yes, complete below:

Carrier's name (Including BCBSM and BCN):	Contract holder name	Policy#	Termination date: / /
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Are any members listed enrolled in Medicare? No Yes If Yes, check reason category Working Aged Retired Disabled ESRD HIC#:

<input type="checkbox"/> Medicare primary	Medicare A effective date: / /	Medicare B effective date: / /	Medicare Part D effective date: / /
<input type="checkbox"/> BCBSM or BCN primary			

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