



ENROLLMENT / CHANGE OF STATUS

Subscriber SSN (or assigned contract number) BCBSM Group Suffix BCN Group ID Subgroup ID Class ID
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SUBSCRIBER INFORMATION

Subscriber Last Name <input type="checkbox"/> check if new										Subscriber First Name										M.I.		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Subscriber Birth Date						Home Phone <input type="checkbox"/> check if new					
Home Street Address <input type="checkbox"/> check if new										City										State		Zip Code		Work Phone <input type="checkbox"/> check if new													
County				Country - if other than USA				Email - optional																													

List all persons to be enrolled / terminated:					M	I	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	* REL CODE
CHECK ONE	LAST NAME	FIRST NAME							
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Delete							/ /		
Dep-1 <input type="checkbox"/> Add <input type="checkbox"/> Delete							/ /		
Dep-2 <input type="checkbox"/> Add <input type="checkbox"/> Delete							/ /		
Dep-3 <input type="checkbox"/> Add <input type="checkbox"/> Delete							/ /		

BCN/POS - PRIMARY CARE PHYSICIAN (PCP)					Seen in the last 12 months?	* Relationship Code	
	PHYSICIAN LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION			
Subscriber					<input type="checkbox"/> Yes	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)***	
Spouse					<input type="checkbox"/> Yes	* = Attach Documentation ** = Attach Court Order *** = Attach Physician Statement PCP Change Reason -BCN/POS Previous BCBSM Affiliation	
Dep-1					<input type="checkbox"/> Yes	I have previously been enrolled in: (Check applicable box) <input type="checkbox"/> BCBSM <input type="checkbox"/> BCN Enter Contract#	
Dep-2					<input type="checkbox"/> Yes		
Dep-3					<input type="checkbox"/> Yes		

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	
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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	
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