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), BLUE CARE NETWORK OF MICHIGAN (BCN) OR BCBSM BLUE CHOICE POINT OF SERVICE (POS).

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.

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 an 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 - M.C. C411
P.O. Box 5043
Southfield, MI 48086

POS/Blue Choice Point of Service Center
P.O. Box 5097
Southfield, MI 48086-5097

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

SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-4:

SECTION 1: Enter subscriber information including: social security or assigned contract number, last name, first name, middle initial, complete home address, marital status, evening and day phone numbers.

SECTION 2: List all persons that you wish to add or delete. ATTACH ADDITIONAL ENROLLMENT FORMS IF NECESSARY TO ADD MORE DEPENDENTS. Include sex, birthdate, social security number and relationship code. Required documentation must be attached to the Enrollment/Change of Status Form. For BCN or POS, using the appropriate paper or web based directory, select the name of a BCN/POS participating primary care physician (PCP) for each person listed. In addition, include physician code - (if known), physician location (street, city) and whether or not seen by the physician within the last 12 months . Indicate, by checking appropriate box, if you have been previously enrolled in BCBSM, BCN or POS. Indicate the contract number under which you were covered. Complete alternate address, if applicable. If changing a PCP, check the PCP change box in Section 5 and include the information listed above for each member changing a PCP and indicate reason for requesting the change. This form does not need to be signed by the group representative for PCP change. If member is requesting a change in PCP only, that can also be done on the internet at www.bcbsm.com or by calling Customer Service.

SECTION 3: If any person listed in Section 2 has other medical insurance coverage either through a group or on an individual basis, please check the "Yes" box. Indicate person covered, group name, policy number, insurance carrier name and location. If you or any person listed in Section 2 is enrolled in Medicare, please check the "Yes" box. **If Yes, attach a copy of the Medicare card(s).** Check applicable box for which Medicare recipient qualifies for Medicare Coverage. POS is not available to Medicare enrollees. If Medicare coverage applies, enrollment will not be processed without a copy of Medicare card(s).

SECTION 4: You must sign the form and indicate date form is completed.

GROUP IS REQUIRED TO COMPLETE SECTION 5 (This form cannot be processed for enrollment purposes without completion of the following):

Coverage Plan for BCN: Please provide group I.D., subgroup I.D. and class I.D., if available. Include group name, representative, signature and date. Indicate the products included, i.e., medical, prescription drugs, hearing, vision, or dental. Check product box. Note: 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, sub group and class I.D. and submit to the appropriate areas.

Coverage Plan For BCBSM: Indicate which products you are selecting. Please provide group name, signature and date. If available, complete BCBSM group number/suffix (8 digits), service code, and badge number or employee I.D. if applicable.

Enrollment: Indicate BCBSM/BCN effective date and subscriber's actual hire/rehire *or* part time to full time status date. Check all applicable enrollment boxes. Health Insurance Portability and Accountability Act (HIPAA) mandates that groups provide special open enrollment periods for their subscribers. These special enrollment periods include enrollment or changes as the result of marriage, birth, adoption, or placement of adoption, loss of eligibility or termination of group contributions.

Reason For Change: To change a subscriber/dependent(s) health care coverage, indicate BCBSM/BCN effective date. Please check the reason for change or indicate HIPAA qualifying event if it is not listed.

Cancel Coverage: Indicate last date of coverage, check off if contract is canceling, spouse is canceling or if a dependent is canceling their coverage. Also check off appropriate reason for the cancellation.

COBRA Enrollment: To enroll terminating member(s) for COBRA health care coverage, please enter the original COBRA qualifying status date.
Also please check the original COBRA qualifying event.

MEDICARE STATUS: Indicate primary coverage per Federal Medicare Secondary Payor (MSP) law(s) and attach copy of Medicare card(s).

PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT

Blue Cross Blue Shield Blue Care Network of Michigan

ENROLLMENT/ CHANGE OF STATUS

SECTION 1 — SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 4

Social Security Number/ Contract Number	Subscriber Last Name ☐ check if new	Subscriber First Name	MI

Home Street Address ☐ check if new	City	State	Area Code/Home Phone

Zip Code	County	Current Marital Status ☐ Single ☐ Married	Area Code/Work Phone

SECTION 2 — SUBSCRIBER

List all persons to be enrolled / terminated:

	Circle One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MMDDYY	SOCIAL SECURITY #	* REL CODE	PRIMARY CARE PHYSICIAN NAME - BCN/POS ONLY: LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION	Seen in the last 12 months: YES	NO
Subscriber	Add Delete				☐M ☐F									
Spouse	Add Delete				☐M ☐F									
Dep-1	Add Delete				☐M ☐F									
Dep-2	Add Delete				☐M ☐F									
Dep-3	Add Delete				☐M ☐F									

* Relationship Code

N - Child (by Birth or Adoption)
S - Stepchild
F - Family Continuation 19+
P - Principal Support*
A - Child Adoption in Process**
L - Legal Guardianship**
SD - Sponsored Dependent*
C - Court Order Coverage (QMCSO)**
D - Disabled Child (PA 275)***

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

Previous BCBSM/POS Affiliation

I have previously been enrolled in : (Check applicable box)

☐ BCBSM ☐ BCN ☐ POS

Enter contract # ____________

PCP Change Reason - BCN/POS ONLY

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

Spouse/Dependent (Full name)	Street Address	City	State	Zip code

SECTION 3 — OTHER COVERAGE

Do you, your spouse or dependent(s) maintain other health coverage? ☐ NO ☐ YES If Yes, complete below:

Person covered (Full name)	Group	Policy Number	Carrier	Location

Are you, your spouse or any dependents listed in section 2 enrolled in Medicare ? ☐ No ☐ Yes **If Yes, attach a copy of Medicare card(s).** ☐ Actively working ☐ Retired ☐ Under 65 ☐ ESRD (End Stage Renal Disease)

SEC. 4 — SIGNATURE

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

Subscriber Signature	Signature Date	Remarks

SECTION 5 — GROUP USE ONLY

GROUP USE ONLY- CHECK AND COMPLETE APPROPRIATE BOXES

BCBSM Group/Suffix or BCN Group I.D./ Subgroup I.D.	BCBSM Service Code/BCN Class I.D.	Employee I.D. Badge #	Group Name	Group Representative Signature	Date

COVERAGE/PLAN: Blue Care Network Plan: ☐ Medical ☐ Rx ☐ Hearing ☐ Vision ☐ Dental | BCBSM Coverage: ☐ Traditional/CMM ☐ POS ☐ PPO ☐ Dental Only ☐ Vision Only

ENROLLMENT: Effective Date: | Date of Hire or Full Time Status: | ☐ New ☐ Part-Time ☐ Hourly ☐ Retiree ☐ Open Enrollment ☐ Return to work from Layoff ☐ Rehire ☐ Full-Time ☐ Salary ☐ Surviving Spouse ☐ HIPAA Qualifying Event (describe event): ____________

REASON FOR CHANGE: Effective Date: | ☐ Marriage ☐ Duplicate ID Card ☐ Name Change ☐ Address Change ☐ Dependent(s) ☐ Loss of Coverage (Certificate of Creditable Coverage Required) ☐ PCP Change ☐ FCR/DCCR ☐ Transfer ☐ HIPAA Qualifying Event (describe event): ____________

CANCEL COVERAGE: Last Date of Coverage: | ☐ Contract ☐ Spouse ☐ Dependent(s) list in Section 2 | REASON: ☐ COBRA ☐ Divorce ☐ Retired ☐ Dependent Over Age ☐ Death ☐ Other Insurance ☐ Left Employment ☐ Other ____________

COBRA ENROLLMENT: Original Qualifying Date: | ☐ Termination ☐ Reduction of Hours ☐ Layoff ☐ Deceased Subscriber ☐ Divorce/Legal Separation ☐ Loss of Dependent Status Previous Contract # ____________

MEDICARE STATUS: Effective Date: | ☐ Medicare Primary per MSP Law(s) ☐ BCBSM/BCN Primary per MSP Law(s) Please attach a copy of Medicare card(s)

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.