Blue Cross Blue Shield Blue Care Network of Michigan

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 Members - Complete Page 4 for PCP Selection

BCBSM group number	Division	BCN group ID	Subgroup	Class ID	Employer representative signature
007041370	0000				

Subscriber information

Date	Social Security number (required)	Subscriber last name	Subscriber first name	M.I.	Marital status	Gender
					☐ S ☐ M	☐ M ☐ F

Subscriber birth date	Home street address	City	State	ZIP code

County	Country - if other than USA	Primary telephone number		Secondary telephone number		E-mail
			☐ Home ☐ Work ☐ Cell		☐ Home ☐ Work ☐ Cell	

List all persons to be covered:

	Last name	First name	MI	Gender	Date of birth	Social Security number	*Relationship code (see instructions for codes)
Spouse				☐M ☐F			
Dep. 1				☐M ☐F			
Dep. 2				☐M ☐F			
Dep. 3				☐M ☐F			
Dep. 4				☐M ☐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

Coordination of benefits information

Do you, your spouse dependents maintain other 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

I have read and understand the conditions of this form. Subscriber signature: Date:

Health savings and flexible spending account options

☐ HSA ☐ HSA Opt out ☐ BCBSM Product indicator code: ☐ Add ☐ Change ☐ Cancel ☐ FSAMED Goal amount: ☐ FSADEPCA Goal amount:

Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Date of hire	Effective date
United Electrical Contractors, Inc.						

Check coverage if applicable: ☑ Medical ☐ Vision ☐ Dental

Check type of enrollment: ☐ Transfer ☐ Return from layoff ☐ Loss of eligibility (prior coverge) ☐ Salary ☐ New ☐ Full time ☐ Rehire ☐ Part time Old group division/subgroup _____ New group division/subgroup _____ ☐ Retiree ☐ Surviving spouse ☐ Hourly ☐ Open enrollment

Average hours worked per week (required): _____

Job title (required): _____

COBRA enrollment Check reason: ☐ Termination ☐ Layoff ☐ Reduction of hours ☐ Loss of dependent status ☐ Divorce or legal separation ☐ Deceased subscriber

Previous contract number

Original qualifying date

Loss of eligibility (prior coverage) ☐ Yes ☐ No If Yes, complete:

Carrier's name (Including BCBSM and BCN)	Contract holder name	Policy number	Termination date

Are any members listed enrolled in Medicare? ☐ No ☐ Yes If Yes, check reason category ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD HIC number:

☐ Medicare primary ☐ BCBSM or BCN primary	Medicare A effective date	Medicare B effective date	Medicare Part D effective date