



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: Relationship code (See instructions for codes)

	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)
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		
Dep. 4 <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

Instructions for completing *Change of Status* form on Page 6

- Indicate if enrolling in BCBSM or BCN. IF BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 if you're changing your PCP.
- Enter BCBSM group and division number (suffix, section code) or BCN group number, subgroup number and BCN class number. Have your employer's HR representative sign and date the *Employer signature* section.

Subscriber information:

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name, and middle initial. Enter the marital status, if changing. Indicate if you are a male or female.
- Enter new home address beginning with street address, city, state and ZIP code. Enter your new e-mail address, if changing.
- Enter new county name for home address and country name (if other than USA). Enter new primary phone, if changing, and indicate if home, work or cell, Enter new secondary phone number and indicate if home, work or cell.
- List all persons to be added or deleted. Enter name(s) on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if all your dependents do not fit on this form.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

N - Child (by birth or adoption)	L - Legal guardianship **
S - Stepchild	SD - Sponsored dependent *
F - Family continuation	C - Court order coverage (QMCSO) **
P - Principal support	D - Disabled child (P.A. 275) ***
A - Child adoption in process **	M - Medicare

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Coordination of benefits information:

- Indicate Yes or No if you, your spouse or dependent maintain other health care coverage. If Yes, list complete name of person covered, group name, policy number, carrier name and address. If other health coverage applies to all members on the contract, check the applicable box.

Flexible spending account arrangements:

- Check all applicable options and enter the goal amount.

Flexible spending arrangement options:

FSAMED – Medical spending account	FSAPARK – Parking flexible spending account
FSADEPCA – Dependent care flexible spending account.	FSATRANS – Transportation flexible spending account

Employer and group use only:

- Enter employer or group name, and employee identification, badge or department number, if applicable. Enter benefit code (service code, package code). Enter plan code (BCBSM plan servicing this contract). Enter date of hire and effective date.
- Indicate the reason for change - *Marriage, Dependents FC/DCR* (Family Continuation, Dependent Continuation Rider) *Name change* or *Loss of coverage*.
- Check the reason for the change. Check the appropriate type of cancellation and reason. For BCN only, complete this *Change of Status* form (Page 6) to cancel active coverage, and complete the *New Subscriber Enrollment* form (Page 2) to enroll in COBRA.
- For prior loss of coverage, indicate Yes or No. If Yes, please indicate the carrier name, contract holder name, policy number and termination date.
- Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare. Indicate if Medicare is primary or if BCBSM or BCN is primary per MSP (mandatory secondary payer) laws, and enter effective date of the Medicare Parts A, B and D coverage. For BCN members, please attach a copy of the Medicare card.