



# SUBSCRIBER NEW ENROLLMENT

(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  S  M  F Gender  M  F Subscriber birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Home street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

County \_\_\_\_\_ Country - if other than USA \_\_\_\_\_  Home  Work  Cell Primary phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Home  Work  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 \_\_\_\_\_

### 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 \_\_\_\_\_

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  New  Transfer  Hourly  Retiree  Return from layoff  Salary  Open enrollment

Average hours worked per week (required): \_\_\_\_\_ Job title (required): \_\_\_\_\_

COBRA enrollment  Termination  Reduction of hours  Divorce or legal separation

Check reason:  Layoff  Loss of dependent status  Deceased subscriber

Previous contract # \_\_\_\_\_ Original qualifying date \_\_\_\_/\_\_\_\_/\_\_\_\_

Loss of prior coverage?  Yes  No If Yes, complete below: \_\_\_\_\_

Carrier's name (Including BCBSM and BCN): \_\_\_\_\_ Contract holder name \_\_\_\_\_ Policy# \_\_\_\_\_ Termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Medicare primary Medicare A effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare B effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare Part D effective date \_\_\_\_/\_\_\_\_/\_\_\_\_

BCBSM or BCN primary

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### Instructions for completing *New Subscriber Enrollment* form on Page 2

- Indicate if enrolling in BCBSM or BCN: If enrolling with BCN, complete the *BCN Primary Care Physician Selection* form on Page 4 to designate your PCP.
- Enter BCBSM group and division number (for example, 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. Indicate whether single or married, male or female. Enter subscriber date of birth.
- Enter home address beginning with street address, city, state and ZIP code. Enter e-mail address.
- Enter county name for home address, country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons to be enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if your 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 account 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.
- For BCBSM only, indicate if employee is enrolling in stand-alone coverage for dental only, vision only or dental and vision only coverage.
- Check type of enrollment (new, rehire, etc.). Indicate the average hours worked per week and the employee's job title. If COBRA enrollment, check the reason for COBRA. Indicate the previous contract number and the original qualifying date.
- For loss of prior 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.

Please provide all documentation for enrollment.