

Instructions for Completing Blue Cross Blue Shield of Michigan Individual Coverage

Change of Status

This form is intended for use by current Blue Cross members to report changes to their contract during a qualifying life event. It is not an application for coverage.

If you enrolled in your Blue Cross plan through the Health Insurance Marketplace, please contact 1-800-318-2596 to report all membership changes rather than fill out this form.

Dental

Under the health care reform law, every insurance plan needs to cover ten categories of essential health benefits including pediatric dental care for children up to age 19. On this change of status form, before any changes can be made to your current plan, you must identify whether you have already purchased a Marketplace-certified plan with pediatric coverage or will have purchased one with pediatric dental coverage that begins on or before the date your medical plan coverage starts.

Counties where Blue DentalSM (EPO) is available: All counties except Mason and Keweenaw

Membership changes

A qualifying life event allows you to enroll in a new health care plan or make changes to your current coverage, generally within 60 days of the event. To complete your change of status request, some events require legal or specific documentation, while others require a signature to confirm the event. Use the chart below to determine what document you might be required to submit with your change of status form.

Event	Documentation requirement
Birth, adoption, placement of foster child or children, guardianship, court-ordered dependent, marriage, divorce or legal separation, death of single policyholder, change in dependent status due to turning age 26 or death of dependent	Complete this form to request change and confirm the membership change with a signature.
Move to another location within Michigan	Complete this form and submit a new driver's license or a rental lease or mortgage agreement.
Loss of employer-sponsored health care coverage; loss of dependent status due to policy holder enrolling in Medicare; loss of coverage due to death of policy holder with dependents; change in full-time employment status resulting in a loss of coverage; COBRA coverage ending; or loss of Medicaid or Children's Health Insurance Program (CHIP)	Any loss of coverage will require you or your dependents to apply for a new health care plan rather than submit a change of status.

Coverage changes

Coverage changes after the annual open enrollment period for individual plans are only allowed with a qualifying life event (for example, marriage, birth or loss of coverage).

Health savings account options

Changes to your health saving account status can be done any time throughout the year. Please visit bcbsm.com/healthybluehsa for additional instructions.

Other changes

Address change:

An address change may result in a change in premium rates. Permanent address changes will require proof of residency (documentation requirement above). In order for an address to be considered temporary, you must live there less than six months a year. An alternate address is for routing of mail only.

Voluntary termination:

To terminate your entire contract with us, complete and sign the change of status form. Terminations must be requested and signed by the contract holder only; unless termination is due to death.

Note: Without a qualifying event to enroll in coverage, termination of a policy may not allow you to enroll in another plan until the next open enrollment period, which starts in the fourth quarter of each year.

Mailing and fax instructions

Mail or fax change of status form along with the required supporting documentation to:

Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407
Fax: **1-866-392-7528**

Premium payments sent to this address could delay access to your benefits.



Subscriber name	Group number	Contract number (13 digits required)

Dental coverage confirmation (required)

I have already purchased a Marketplace-certified plan with pediatric dental coverage. I will have purchased a Marketplace-certified plan with pediatric dental coverage that begins on or before the date my medical plan coverage starts.

Member changes

Check reason for change below: Reason : <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Birth <input type="checkbox"/> Other _____					Check reason for removal of member below: Reason : <input type="checkbox"/> Death <input type="checkbox"/> Enrolled in Medicare <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____			
	Last name	First name	Middle initial	Sex	Date of birth MM/DD/YYYY	Social Security number	Date of event	*Rel code
Spouse <input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female				
Dependent 1 <input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female				
Dependent 2 <input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female				
Dependent 3 <input type="checkbox"/> Add <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female				

* Relationship codes: A - Child adoption in progress L - Legal guardianship S - Stepchild
 C - Court order coverage N - Biological or adopted child SP - Spouse
 D - Disabled child P - Principal support

Health status (required for the addition of any members older than 18)

During the past six months, has any new dependent age 18 and older been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?*

Yes No If yes, whom? _____
*Blue Cross reserves the right to verify tobacco use and to adjust your premium accordingly. Please see Terms and Conditions for additional information at bcbsm.com.

Coverage changes (choose the plan you want to enroll in)

2016 Medical

<input type="checkbox"/> Blue Cross® Premier Platinum with Dental & Vision	<input type="checkbox"/> Blue Cross® Premier Gold	<input type="checkbox"/> Blue Cross® Premier Gold Extra	<input type="checkbox"/> Blue Cross® Metro Detroit EPO Gold Extra	<input type="checkbox"/> Blue Cross® Premier Silver
<input type="checkbox"/> Blue Cross® Premier Silver Extra	<input type="checkbox"/> Blue Cross® Metro Detroit EPO Silver	<input type="checkbox"/> Blue Cross® Metro Detroit EPO Silver Extra	<input type="checkbox"/> Blue Cross® Premier Silver Saver	<input type="checkbox"/> Blue Cross® Premier Bronze
<input type="checkbox"/> Blue Cross® Premier Bronze with Primary Care visits	<input type="checkbox"/> Blue Cross® Metro Detroit EPO Bronze <input type="checkbox"/> HSA*	<input type="checkbox"/> Blue Cross® Premier Bronze Saver	<input type="checkbox"/> HSA*	<input type="checkbox"/> Blue Cross® Premier Value (you must be age 29 or younger when the coverage starts or qualify for a hardship exemption)

* HSA, Powered by HealthEquity Exclusive provider organization (or EPO) is only available in Wayne, Oakland, Macomb, St. Clair, Livingston and Washtenaw counties

2016 Dental

<input type="checkbox"/> Blue Dental SM PPO Standard*	<input type="checkbox"/> Blue Dental SM PPO Standard with Vision*	<input type="checkbox"/> Blue Dental SM PPO Plus Standard *	<input type="checkbox"/> Blue Dental SM PPO Plus Standard with Vision *
<input type="checkbox"/> Blue Dental SM EPO Standard*	<input type="checkbox"/> Blue Dental SM EPO Standard with Vision*	<input type="checkbox"/> Blue Dental SM PPO Extra *	<input type="checkbox"/> Blue Dental SM PPO Extra with Vision *
<input type="checkbox"/> Blue Dental SM PPO Pediatric **			

* Available to all ages; benefits cover all ages. Exclusive Provider Organization (or EPO) counties are listed on instruction page.
**Available to all ages but the benefits only cover members through the end of the year they turn 19. A member cannot be older than 18 on their effective date to receive benefits. Members older than 18 can select this plan but will not have access to any benefits and will have a \$0 rate premium.

Other changes

<input type="checkbox"/> Name change	Last name	First name	Middle initial
<input type="checkbox"/> Address change Permanent <input type="checkbox"/> Temporary <input type="checkbox"/>	Residential address	City	State ZIP code
	Alternate address	City	State ZIP code
<input type="checkbox"/> Telephone number change	Home	Cell	

Voluntary contract termination (signature of subscriber required)

Please terminate this contract. Termination date will be effective as of the receipt of this request, unless you specify a future termination date. Requested date: _____
Note: Without a qualifying event to enroll in coverage, termination of a policy may not allow you to enroll in another plan until the next open enrollment period, which starts in the fourth quarter of each year.

Signature (required)

*I understand that a summary of benefits and coverage related to the coverage change requested is available at bcbsm.com/sbc. I understand the summary of benefits and coverage is not a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the summary of benefits and my applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the summary of benefits and coverage electronically on the website. I understand a paper copy is also available, free of charge, by calling Blue Cross Blue Shield of Michigan at 1-888-288-2738. This is a toll-free number. I verify that the qualifying life event information provided on this form is true and correct to the best of my knowledge.
(Blue Cross reserves the right to require additional documentation as proof of the event.)*

_____/_____/_____ _____/_____/_____ Date

Agent information (completed by agent only). This will not change or add the agent of record.

Agent code	MA/GA code	Association/Chamber code	Managing agent/General agent/Agent signature

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.