Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Instructions for Completing Blue Care Network 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 Care Network 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.

## 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 a 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 termporary, 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 Care Network of Michigan**
P.O. Box 5043
Southfield, MI 48086-5043
Fax: **1-877-218-1466**

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

Blue Care Network of Michigan

| 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* : ☐ Marriage ☐ Open enrollment ☐ Birth ☐ Other _____

Check reason for removal of member below:

*Reason* : ☐ Death ☐ Enrolled in Medicare ☐ Divorce ☐ Other _____

| | Last name | First name | Middle initial | Sex | Date of birth MM/DD/YYYY | Social Security number | Date of event | *Rel code |
|---|---|---|---|---|---|---|---|---|
| Spouse ☐ Add ☐ Remove | | | | ☐ Male ☐ Female | | | | |
| Dependent 1 ☐ Add ☐ Remove | | | | ☐ Male ☐ Female | | | | |
| Dependent 2 ☐ Add ☐ Remove | | | | ☐ Male ☐ Female | | | | |
| Dependent 3 ☐ Add ☐ Remove | | | | ☐ Male ☐ Female | | | | |

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

## 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 Care Network 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*

| | | | | |
|---|---|---|---|---|
| ☐ Blue Cross® Partnered **Gold** | ☐ Blue Cross® Select **Gold** | ☐ Blue Cross® Preferred **Gold** | | |
| ☐ Blue Cross® Partnered **Gold Extra** | ☐ Blue Cross® Select **Gold Extra** | ☐ Blue Cross® Preferred **Gold Extra** | ☐ Blue Cross® Metro Detroit HMO **Gold Extra** | |
| ☐ Blue Cross® Partnered **Silver** | ☐ Blue Cross® Select **Silver** | ☐ Blue Cross® Preferred **Silver** | ☐ Blue Cross® Metro Detroit HMO **Silver** | |
| ☐ Blue Cross® Partnered **Silver Extra** | ☐ Blue Cross® Select **Silver Extra** | ☐ Blue Cross® Preferred **Silver Extra** | ☐ Blue Cross® Metro Detroit HMO **Silver Extra** | ☐ Blue Cross® Select Value (you must be age 29 or younger when the coveage starts or qualify for a harship exemption) |
| ☐ Blue Cross® Partnered **Silver Saver** | ☐ Blue Cross® Select **Silver Saver** | | ☐ Blue Cross® Metro Detroit HMO **Silver Saver** | |
| ☐ Blue Cross® Partnered **Bronze** ☐ **HSA*** | ☐ Blue Cross® Select **Bronze** ☐ **HSA*** | ☐ Blue Cross® Preferred **Bronze** ☐ **HSA*** | ☐ Blue Cross® Metro Detroit HMO **Bronze** ☐ **HSA*** | |
| ☐ Blue Cross® Partnered **Bronze Saver** ☐ **HSA*** | ☐ Blue Cross® Select **Bronze Saver** ☐ **HSA*** | | ☐ Blue Cross® Metro Detroit HMO **Bronze Saver** ☐ **HSA*** | |

* HSA, Powered by HealthEquity

## Other changes

| | | | | |
|---|---|---|---|---|
| ☐ Name change | Last name | First name | | Middle initial |
| ☐ Address change<br>Permanent ☐<br>Temporary ☐ | Residential address | City | State | ZIP code |
| | Alternate address | City | State | ZIP code |
| ☐ 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 Care Network of Michigan at 1-888-227-2345. 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.)*

_____ **Subscriber signature**

_____/_____/_____ **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 |
|---|---|---|---|
| | | | |