

## Enrollment Change of Status Form (ECOS)

**PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE ATTACHED ENROLLMENT CHANGE OF STATUS FORM.**

**THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH  
BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) OR BLUE CARE NETWORK OF MICHIGAN (BCN).**

I am applying for coverage for myself and my family members identified on this application under my group's or association's contract with BCBSM or BCN (BCBSM/BCN). Coverage begins on the date determined by BCBSM/BCN. When BCBSM/BCN accepts my application, I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility:** I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM/BCN.

**Authorization:** I appoint my group or association to handle all matters of coverage. It may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM/BCN and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM/BCN, and for other purposes necessary for BCBSM/BCN to fulfill its contractual and statutory obligations.

**Release of Information:** I acknowledge that BCBSM/BCN requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM/BCN for purposes of administering our coverage. Upon my request, BCBSM/BCN will tell me where the information was sent.

**COBRA:** I will not be eligible for a waiver of any preexisting exclusion in BCBSM non-group coverage if I do not elect and exhaust any COBRA coverage available to me.

If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer I authorize BCBSM/BCN to provide claims information pertaining to me and my covered dependents to the account administrator to facilitate reimbursement.

### BLUE CARE NETWORK ONLY

I and my enrolled family members agree that all of our medical services must be performed, prescribed, directed or authorized by our designated BCN Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency when the time needed to contact our Primary Care Physician(s) may mean permanent damage to our health. Unauthorized services that are not an immediate emergency, as described above, received from non-Blue Care Network providers will not be covered.

The BCN service area excludes Branch, Lake, Lenawee, Mason, Missaukee, Osceola and Sanilac counties. Residents of these counties may receive services in a BCN covered county by providing BCN with and Out of Area Waiver at the time of enrollment.

I agree to assign to BCN my entire right of recovery of the cost of hospital, medical and prescription services delivered by or paid for by BCN against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts, whether by redemption award or voluntary payment or otherwise.

I authorize any holder of medical or other information about me or my enrolled family members to release to the Centers for Medicare and Medicaid Services, any insurance company, or any HMO and their agents any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company, or HMO benefits be made payable to BCN on my behalf for any services furnished to me and my enrolled family members by BCN.

### BLUE CHOICE POINT OF SERVICE ONLY

I and my enrolled family members agree that all our medical services must be performed, prescribed, directed or authorized by our designated POS Primary Care Physician(s) except in the case of an immediate and unforeseen medical emergency and the time needed to contact our Primary Care Physician(s) may mean permanent damage to our health. Unauthorized services that are not an immediate and unforeseen emergency, as described above, will be subject to applicable out of network deductibles and copays.

**Send completed form to:**

Blue Cross Blue Shield of Michigan  
Membership and Billing – 1704  
P.O. Box 2260  
Detroit, MI 48231-2260  
Fax: 313-225-0932 or  
313-225-0936 or  
313-225-4865

Blue Care Network  
Membership Department – C411  
P.O. Box 5043  
Southfield, MI 48086  
Fax: 877-218-1466

# ENROLLMENT / CHANGE OF STATUS



Subscriber SSN (or assigned contract number)  -  -  BCBSM Group  -  Suffix  BCN Group ID  Subgroup ID  Class ID

### SUBSCRIBER INFORMATION

Subscriber Last Name   check if new Subscriber First Name  M.I.  Marital Status  S  M  M  F Gender  M  F Subscriber Birth Date  /  /  Home Phone  -  -   check if new

Home Street Address   check if new City  State  Zip Code  Work Phone  -  -   check if new

County  Country - if other than USA  Email - optional

List all persons to be enrolled / terminated:				M	I	DATE OF BIRTH	SOCIAL SECURITY #	* REL CODE
	CHECK ONE	LAST NAME	FIRST NAME			MM/DD/YYYY		
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-1	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-2	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		
Dep-3	<input type="checkbox"/> Add <input type="checkbox"/> Delete					/ /		

BCN/POS - PRIMARY CARE PHYSICIAN (PCP)					Seen in the last 12 months?	* Relationship Code	
	PHYSICIAN LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION			
Subscriber					<input type="checkbox"/> Yes	N - Child (by Birth or Adoption)    A - Child Adoption in Process** S - Stepchild    L - Legal Guardianship** F - Family Continuation 19+    SD - Sponsored Dependent* P - Principal Support*    C - Court Order Coverage (QMCSO)** D - Disabled Child (BCBSM - PA350) (BCN - PA218)***	
Spouse					<input type="checkbox"/> Yes	* = Attach Documentation    ** = Attach Court Order    *** = Attach Physician Statement	
Dep-1					<input type="checkbox"/> Yes	PCP Change Reason -BCN/POS	Previous BCBSM Affiliation
Dep-2					<input type="checkbox"/> Yes		I have previously been enrolled in: (Check applicable box) <input type="checkbox"/> BCBSM <input type="checkbox"/> BCN Enter Contract#
Dep-3					<input type="checkbox"/> Yes		

If the permanent address of the spouse or dependent is different from the address above, please complete the information below:

Spouse/Dependent (Full Name)  Street Address  City  State  Zip code

Do you, your spouse or dependent(s) maintain other health coverage?  NO  YES If Yes, complete below: Check here if this applies to all members on the contract:

Person covered (Full Name) <input type="text"/>	Group Name <input type="text"/>	Policy Number <input type="text"/>	Carrier <input type="text"/>	Location <input type="text"/>
Person covered (Full Name) <input type="text"/>	Group Name <input type="text"/>	Policy Number <input type="text"/>	Carrier <input type="text"/>	Location <input type="text"/>

Are you, your spouse or any dependent(s) listed enrolled in Medicare?  NO  YES If Yes, attach a copy of Medicare card(s).  Actively working  Retired  Under 65  ESRD (End Stage Renal Disease)

**I have read and understand the conditions on page 1 of this form.**

Subscriber Signature  Signature Date  Remarks



# ENROLLMENT / CHANGE OF STATUS

	Subscriber Last Name		Subscriber First Name	M.I.
	Subscriber SSN	BCBSM Group	Suffix	BCN Group ID
	Subgroup ID	Class ID		

## Group Use Only - Check and Complete Appropriate Boxes

Group Name		Employee I.D. Badge #
BCBSM Service Code	Group Representative Signature	
Date		
Coverage/Plan:	Check if enrolling in : <input type="checkbox"/> BCBSM <input type="checkbox"/> Blue Care Network	Check all applicable coverage (including all existing coverage you wish to maintain): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

### Enrollment, Reason For Change, Cancel Coverage, COBRA Enrollment, HIPAA Qualifying Events, Medicare Status

<b>NEW</b> , Check Type of Enrollment below: <input type="checkbox"/> New <input type="checkbox"/> Retiree <input type="checkbox"/> Rehire <input type="checkbox"/> Hourly <input type="checkbox"/> Full Time <input type="checkbox"/> Salary <input type="checkbox"/> Part Time <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Transfer <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Return to Work from layoff  Date Of Hire - (required)    Job Title: (required) / / Effective Date / /	<b>CHANGE</b> , Check applicable change below: <input type="checkbox"/> Marriage <input type="checkbox"/> Name Change <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> FCR/DCCR <input type="checkbox"/> PCP Change  Date of Event / / Effective Date / /	<b>CANCEL</b> , check type of cancellation & reason below: TYPE: <input type="checkbox"/> Contract <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) REASON: <input type="checkbox"/> COBRA <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other Insurance <input type="checkbox"/> Retired <input type="checkbox"/> Left Employment <input type="checkbox"/> Dependent Over Age <input type="checkbox"/> Other Last Date of Coverage / /	<b>COBRA</b> Enrollment, check reason below: <input type="checkbox"/> Termination <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Layoff <input type="checkbox"/> Deceased Subscriber <input type="checkbox"/> Reduction of Hours <input type="checkbox"/> Loss of Dependent Status  Previous Contract #  Original Qualifying Date / /
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If transfer/loss of coverage, complete below: Carrier's Name  Contract Holder Name  Policy #    Termination Date / /	<b>Medicare Status</b>	<input type="checkbox"/> Medicare Primary per MSP Law(s) <input type="checkbox"/> BCBSM/BCN Primary per MSP Law(s)  Effective Date / /  Attach a copy of Medicare card(s)
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### Blue Healthcare Bank Options - complete the following additional information:

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Effective Date / /	<input type="checkbox"/> HRA Health Reimbursement Arrangement <input type="checkbox"/> HSA Health Savings Account    Goal Amount* <input type="checkbox"/> FSA Flexible Spending Account	<input type="checkbox"/> LPHRA-B Limited Purpose Health Reimbursement Account    Goal Amount* <input type="checkbox"/> DCFSA-B Dependent Care Flexible Spending Account <input type="checkbox"/> LPFSA-B Limited Purpose Flexible Spending Account
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\*Total Annual Dollar Amount employee will contribute to the applicable FSA account.

Additional Blue Healthcare Bank options :

INSTRUCTIONS FOR COMPLETING ENROLLMENT/CHANGE OF STATUS FORM  
ALL SECTIONS MUST BE COMPLETED BEFORE FORM CAN BE PROCESSED

**Page 2 – Subscriber Information**

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Subscriber Last Name (check box if new), Subscriber First Name, and Middle Initial. If there is not enough spaces to accommodate your full name, print or type full name in the remarks section at the bottom of page 3. Indicate whether single or married, male or female.
- Enter Subscriber date of birth, home phone number (check box if new).
- Enter home address beginning with street address (check box if new), City, State & Zip Code. Enter work phone number (check box if new).
- Enter county name for home address, Country name (if other than USA), email address.
- List all persons to be enrolled/terminated: Enter name(s) on appropriate line – spouse, dependent 1, 2, and 3 as applicable. Complete additional forms if more dependents are to be covered. Check if they are to be added or deleted. Enter last name, first name, middle initial, male or female, date of birth, social security number and rel code (relationship codes are listed below).
- BCN/POS Only - Enter physician last name, first initial, physician number and location for each member (subscriber, spouse, dependent 1, 2, and 3). Check the box if the member has been seen by the designated physician within the last 12 months.
- BCN/POS Only - PCP Change Reason – enter reason for request to change primary care physician. Group representative signature not required. Change can also be made at MiBCN.com., if BCN.
- Previous BCBSM Affiliation – check if previously enrolled in either BCBSM or BCN and enter contract number.
- Permanent Address – Enter the spouse/dependents address if different from the address indicated above.
- Other Health Coverage - Indicate no or yes if you, your spouse or dependent maintain other health care coverage – if yes, complete name of person covered, group name, policy number, carrier name and location. If other health coverage applies to all members on the contract, check the applicable box.
- Indicate if you, your spouse or dependent are enrolled in Medicare – if yes, a copy of your Medicare card(s) is required, check off applicable status: actively working, retired, under 65 or ESRD (End Stage Renal Disease).
- In the signature section, sign your full name, enter the date you signed the form and make any notations in the remarks field.

**Page 3 – Group Use only – check and complete appropriate boxes**

- Enter Subscriber Social Security Number or assigned contract number. BCBSM Group & Suffix number or BCN Group ID number, Subgroup ID number & BCN Class ID number.
- Enter Group name and employee Identification Badge number, if applicable.
- BCBSM Only: Enter BCBSM Service Code (12 digit), Group Representative Signature and date.
- Indicate if subscriber is enrolling in either BCBSM or Blue Care Network, check all applicable coverage the subscriber is enrolling in even coverage they wish to maintain – medical, dental, vision. If enrolling in BCN and there is a separate group number for your BCBSM dental or vision product, complete two Enrollment Change of Status forms – one with BCBSM Dental/Vision group/suffix number and one with the BCN group, subgroup and class I.D. and submit to the appropriate areas (see bottom on page 1).
- **NEW** Section: check applicable box, enter date of hire, effective date, average number of hours worked per week and job title.
- **CHANGE** section: to change a subscriber/dependent(s) health care coverage check the appropriate box, enter date of event and effective date.
- **CANCEL** Section: check applicable box for contract holder, spouse or dependent, check reason for canceling and enter last date of coverage.
- **COBRA** Section: check reason, enter previous contract number and enter the original qualifying status date.
- **TRANSFER/LOSS OF COVERAGE** Section: if you checked transfer in the new section above, or loss of coverage in the change section above, indicate the carrier's name, contract holder name, policy number and termination date.
- **MEDICARE STATUS** Section: indicate if Medicare is primary or BCBSM/BCN is primary per MSP (Mandatory Secondary Payer) law(s), enter effective date of the Medicare coverage and attach a copy of the Medicare card(s).
- **BLUE HEALTHCARE BANK OPTIONS** Section: indicate if Blue Healthcare Bank is being added, changed or canceled. Enter the effective date, check off applicable options. If any of the FSA options are selected also enter the goal amount. If additional options are offered, write the option(s) in the Blue Healthcare Bank options area.

PLEASE PROVIDE ALL DOCUMENTATION REQUIRED FOR ENROLLMENT