

Nongroup/Group Conversion Enrollment Change of Status Form (ECOS)

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THE ATTACHED NONGROUP/GROUP CONVERSION 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 AND BLUE CARE NETWORK OF MICHIGAN.

I am applying for coverage for myself and my family members identified on this application. 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 of my 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.

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 an 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.

Send completed form to:

Membership and Billing – Mail Code 1704
Blue Cross Blue Shield of Michigan
P.O. Box 2260
Detroit, MI 48231-2260

Membership Department – Mail Code C411
Blue Care Network
P.O. Box 5043
Southfield, MI 48086

INSTRUCTIONS FOR COMPLETING NONGROUP/GROUP CONVERSION ENROLLMENT/CHANGE OF STATUS FORM

All sections must be completed before form can be processed.

SUBSCRIBER IS REQUIRED TO COMPLETE SECTIONS 1-4:

- SECTION 1:** Enter subscriber information including: Social Security or assigned contract number, last name, first name, middle initial, complete home address, marital status, evening and day phone numbers.
- SECTION 2:** List all persons whom you wish to add or delete. ATTACH ADDITIONAL ENROLLMENT FORMS IF NECESSARY TO ADD MORE DEPENDENTS. Include sex, date of birth, Social Security number and relationship code. Required documentation must be attached to the Nongroup/Group Conversion Enrollment/Change of Status Form. Using the appropriate paper or web-based directory, select the name of a BCN/BCBSM participating primary care physician for each person listed. Include physician code (if known), physician location (street, city) and whether or not seen by the physician within the last 12 months. Indicate, by checking the appropriate box, if you have been previously enrolled in BCBSM or BCN. Indicate the contract number under which you were covered. Complete alternate address, if applicable.
- SECTION 3:** If any person listed in Section 2 has other medical insurance coverage either through a group or on an individual basis, please check the "Yes" box. Indicate the person covered, group name, policy number, insurance carrier name and location. If you or any person listed in Section 2 is enrolled in Medicare, please check the "Yes" box. **If Yes, indicate the effective date and attach a copy of the Medicare card(s).** Check applicable box for which Medicare recipient qualifies for Medicare Coverage.
- SECTION 4:** Sign and date the form.
- SECTION 5:** Reserved for BCN use.

**NONGROUP/GROUP
CONVERSION
ENROLLMENT
CHANGE OF STATUS FORM**

SECTION 1	SUBSCRIBER INFORMATION - COMPLETE SECTIONS 1 THROUGH 4								
	Social Security Number/ Contract Number		Subscriber Last Name <input type="checkbox"/> check if new		Subscriber First Name		Middle Initial		
	Home Street Address <input type="checkbox"/> check if new			City		State	Area Code/Home Phone		
	Zip Code		County		Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Area Code/Work Phone		

SUBSCRIBER SECTION 2	List all persons to be enrolled/terminated:										PRIMARY CARE PHYSICIAN NAME				Seen in the last 12 months	
	Circle One Add Delete	LAST NAME	FIRST NAME	M	S E X	DATE OF BIRTH MMDDYY	SOCIAL SECURITY #	* C O D E	LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATION STREET/CITY	YES	NO		
															I	F
Subscriber																
Spouse																
Dep-1																
Dep-2																
Dep-3																

* Relationship Code										Previous BCBSM Affiliation			
N - Child (by Birth or Adoption) P - Principal Support* SD - Sponsored Dependent* * = Attach Documentation S - Stepchild A - Child Adoption in Process** C - Court Order Coverage (QMCSO)** ** = Attach Court Order F - Family Continuation 19+ L - Legal Guardianship** D - Disabled Child (PA 275)*** *** = Attach Physician Statement										I have previously been enrolled in: (Check applicable box) <input type="checkbox"/> BCBSM <input type="checkbox"/> BCN <input type="checkbox"/> COBRA Enter contract # _____			

If the permanent address of the spouse or dependent is different from address in section 1, please complete information below:

Spouse/Dependent (Full name)	Street Address	City	State	Zip code
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Do you, your spouse or dependent(s) maintain other health coverage? <input type="checkbox"/> NO <input type="checkbox"/> YES If Yes, complete below:				
Person covered (Full name)	Group	Policy Number	Carrier	Location
Person covered (Full name)	Group	Policy Number	Carrier	Location

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare ? No Yes If Yes, What is the effective date _____ and please 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

BCN USE ONLY

BCBSM Group/Suffix or BCN Group I.D./ Subgroup I.D.		BCBSM Service Code/BCN Class I.D.		Employee I.D. Badge #		Date	
BCN USE ONLY SECTION 5	ENROLLMENT:	Effective Date:	<input type="checkbox"/> New <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____ <input type="checkbox"/> Retiree <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____				
	REASON FOR CHANGE:	Effective Date:	<input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage (Certificate of Creditable Coverage Required) <input type="checkbox"/> PCP Change <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Transfer <input type="checkbox"/> HIPAA Qualifying Event (describe event): _____ <input type="checkbox"/> Duplicate ID Card <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change				
CANCEL COVERAGE:	Last Date of Coverage:	REASON: <input type="checkbox"/> Contract <input type="checkbox"/> COBRA <input type="checkbox"/> Dependent over age <input type="checkbox"/> Left Employment <input type="checkbox"/> Spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ <input type="checkbox"/> Dependent(s) list in Section 2 <input type="checkbox"/> Retired <input type="checkbox"/> Other insurance					