



To be eligible for this coverage, you must live in Michigan at least six months a year and cannot be enrolled in Medicare.

# One Blue<sup>SM</sup> Enrollment Form

Please Print Clearly

Subscriber Social Security Number			Subscriber Last Name			Subscriber First Name			M.I.	Area Code/Evening Phone		Area Code/Day Phone		
Street Address					City			State	Zip Code		County		Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
List all persons to be enrolled/terminated									Primary Care Physician Name - BCN only					Seen in last 12 mo. or current patient?
Subscriber	Circle One	Last Name	First Name	MI	Sex	Date of Birth Mo. Day Year	Social Security Number	*Rel. Code	Last Name	First Name	Phys. Code	Physician City		
	Subscriber	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dep. 1	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dep. 2	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dep. 3	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 4	Add Delete			<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Relationship Code			Are you or your spouse a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No*				PCP Change Reasons - BCN Only			
N - Child (By Birth or Adoption)	P - Principal Support*	SD - Sponsored Dependent*	Note: You must also complete and have your primary care physician sign a Smoking Status Form. We will mail it to you. *If no, you may be required to take a nicotine screening.				<hr/> <hr/> <hr/> <hr/>			
S - Stepchild	A - Child Adoption in Process**	C - Court Order Coverage (QMCSO)								
F - Family Continuation 19+	L - Legal Guardianship**	D - Disabled Child (Pa 275)***								
* = Attached legal documentation										
** = Attached Court Order										
*** = Attached Physician Statement										

- I live in Michigan six or more months each year.  Yes  No
- Are you currently active under a Blue Cross Blue Shield of Michigan or Blue Care Network employer-sponsored group health plan?  Yes  No
  - Have you left a (BCBSM or BCN) employer-sponsored group health plan within the last 30 days?  Yes  No
- What was your last employer's name and end date? Last Employer \_\_\_\_\_ Contract Number \_\_\_\_\_ Policy End Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Are any individuals listed above:
  - Enrolled in Medicare?  Yes  No
  - Eligible for or enrolled in a group-sponsored health plan?  Yes  No If yes, when will the current policy terminate? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  - Enrolled in an individual (nongroup) health plan?  Yes  No If yes, when will the current policy terminate? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Does your employer pay for or reimburse you for all or part of your health care coverage or provide you with a health care plan?  Yes  No

I am applying for Individual coverage subject to the terms and conditions in the material that accompanied this application, and I agree that I and my covered dependents will be bound by all provisions in the individual HMO certificate and riders. Approval of this application and coverage effective date will be determined by BCN and shall be subject to requirements by BCN for additional information and payment of bills. I certify that the requirements of eligibility are met and that the Information I have given on this application is true and correct to the best of my knowledge. I authorize BCN to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCN has the right to use and disclose these records and other confidential member information for valid business purposes. I understand that I may cancel my individual coverage in writing within 72 hours of its effective date and that my previous payment will be refunded promptly. I understand that I must pay a reasonable fee for any services I or my dependents receive from BCN during the 72 hours. Payment must be made at the time of application.

Shaded Areas Are For BCN use Only

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Agent Number		MA Code	Assoc./Chamber Code		Contract Number		Service Code	Eff. Date	U/W	Preex Date	DEID
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**INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL ENROLLMENT FORM** *ALL SECTIONS MUST BE COMPLETED BEFORE ANY CLAIMS CAN BE PROCESSED*

**Demographic information:**

- The address should include apartment number or P.O. Box when applicable.
- List all persons that you wish to cover (including yourself) and identify their relationship to you (e.g., Natural child, Stepchild).
- In divorce/ paternity cases, include appropriate Parental Responsibility Code (e.g., 1-father responsible for health insurance and has legal custody). Legal documentation must be attached (e.g., divorce decree, custodial decree).
- Include birthdate, gender and social security number of each person.
- Indicate the name of a BCN primary care physician selected for each person listed. In addition, include physician code (if known), provider location (street and city), whether or not seen by the chosen PCP within last 12 months or a current patient. Complete alternate addresses for spouse or dependents if applicable.

**Other medical coverage:**

If any person listed has other medical insurance coverage either through an employer or on an individual basis, indicate person covered, the employer, if applicable, policy number, and insurance carrier/HMO name and location.

**Sign and date:** Sign and date the form before submitting it to the address below.

**Return completed enrollment form to:**

Audit Specialist – C411  
Blue Care Network of Michigan  
P. O. Box 5043  
Southfield, MI 48086-9929

Customer Service Inquiries 800-662-6667  
TTY for the hearing impaired: 800-257-9980  
8 a.m. to 5 p.m. Monday through Friday

**CONDITIONS FOR COVERAGE**

- I understand that I am applying for myself and eligible members of my family for health coverage in the individual health plan offered by Blue Care Network of Michigan (BCN). The coverage shall not exceed those benefits and services contained on the certificate and riders.
- I may enroll my legal spouse and eligible children who reside in Blue Care Network's service area. Eligible children are defined as children of mine or my spouse, by birth, legal adoption, foster parenthood, or legal guardianship. Eligible children must be under 18 years of age or younger, financially dependent upon me, or are a part of my household. I may not enroll myself, my spouse, or any dependents who are eligible for, beneficiaries of, or recipients of Medicare or Medicaid or who are eligible for any employer sponsored health benefit plan.
- **ON BEHALF OF MYSELF AND MY ENROLLED FAMILY MEMBERS, I AGREE THAT ALL 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 UNFORSEEN MEDICAL EMERGENCY AS THOSE TERMS ARE DEFINED IN THE COVERAGE DOCUMENTS.**
- I authorize Blue Care Network of Michigan and my Primary Care Physician to obtain the medical records relating to me and my enrolled family members for all purposes permitted by state and federal law, including, coordination of our medical care, administration of my coverage and other purposes necessary for BCN to fulfill its contractual and statutory obligations.
- I authorize any holder of medical or other information about me or my enrolled family members to release to the Health Care Financing Administration, Medicaid, 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 Blue Care Network of Michigan on my behalf for any services furnished to me by Blue Care Network.
- With regard to costs of hospital and medical services delivered by or paid for by BCN, I agree to assign to BCN, my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under worker's compensation laws or acts whether by redemption award or voluntary payment or otherwise.
- I understand that the benefits my enrolled family members and I will be eligible for are described in the applicable Certificate, and that Blue Care Network's marketing materials are only a summary.
- I understand that I may protest a proposed amendment in this contract or rate charged within 30 days of receipt of notice, and that my continued payment while an appeal is in progress shall not be deemed to constitute acceptance of the proposed amendment or rate change.
- I understand that I may cancel this contract within 72 hours of signing this form, and that my previous payment will be refunded promptly. I understand that I must pay a reasonable fee for any services my dependents or I receive from Blue Care Network during the 72 hours.
- **I UNDERSTAND THAT DURING THE SIX MONTH PERIOD FOLLOWING THE EFFECTIVE DATE, MY ENROLLED FAMILY MEMBERS AND I WILL NOT BE COVERED FOR ANY AND ALL CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN 6 MONTHS BEFORE MY ENROLLMENT. THE TERM "CONDITIONS" INCLUDES, BUT IS NOT LIMITED TO, MATERNITY CARE, OBSTETRICAL CARE, AND TERMINATION OF PREGNANCY. I UNDERSTAND THAT MY ENROLLMENT DATE BEGINS ON THE EFFECTIVE DATE OF COVERAGE AS DETERMINED BY BLUE CARE NETWORK.**
- **I UNDERSTAND THAT ACCEPTANCE OF MY APPLICATION WILL BE SUBJECT TO MEDICAL UNDERWRITING.**
- If transferring from BCBSM, or other Blue Care Network coverage, I further understand that the exclusions for the pre-existing conditions listed above will be waived, only to the extent that my enrolled family members and I have satisfied the waiting period, provided there is no lapse in coverage when transferring to BCN individual coverage.
- I certify the above information is true, correct, and complete to the best of my knowledge. I understand the information will be used in reviewing my application and administering coverage and my failure to provide complete and accurate answers or my submission of false or misleading information may result in voiding of coverage for myself and my enrolled family members, denial of claims and/or cancellation.