

**INSTRUCTIONS FOR COMPLETING THE PERSONAL PLUS ENROLLMENT FORM  
ALL SECTIONS MUST BE COMPLETED BEFORE CLAIM CAN BE PROCESSED**

**PLEASE PRINT OR TYPE ALL INFORMATION (press firmly to complete all copies)**

- Section 1: Address should include apartment number or P.O. box when applicable.  
List all persons that you wish to cover including yourself and their relationship to you (i.e., N-Natural Child, Stepchild).  
In divorce/paternity cases, include appropriate Parental Responsibility Code (i.e., 1- father responsible for health insurance and has legal custody). Legal documentation must be attached (i.e., divorce decree, custodial decree, etc.).  
Include birthdate, sex and social security number of each person. Indicate the name of a BCN participating physician for each person listed. In addition, include physician code – if known, provider location (street and city), whether or not seen by provider within last 12 months or a current patient.  
Complete alternate addresses for spouse or dependents if applicable.
- Section 2: If any person listed in Section 1 has other medical insurance coverage either through an employer or on an individual basis, indicate person covered, employer, policy number, insurance carrier/HMO name and location.
- Section 3: You must sign form and indicate date form is completed.

**Customer Service**

800-662-6667

TTY for the hearing impaired: 800-257-9980  
8 a.m. to 5:30 p.m. Monday through Friday

**Please address inquiries to:**

Audit Specialist – MC C411  
Blue Care Network  
P.O. Box 5043  
Southfield, MI 48086-9939

MiBCN.com

**CONDITIONS FOR COVERAGE:**

I understand that I am applying for myself and eligible members of my family for health coverage in the Personal Plus Program offered by Blue Care of Michigan, Inc. administered by Blue Care Network of Michigan (BCN). The coverages shall not exceed those benefits and services contained on the Personal Plus certificate and riders.

I may enroll my legal spouse and eligible children who reside in the Blue Care of Michigan, Inc. service area. Eligible children are defined as my or my spouses' children by birth, legal adoption, foster parenthood, or legal guardianship. Eligible children must be under 18 years of age, 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, recipients of Medicare or Medicaid or who are eligible for any employer sponsored health benefit plan.

**I AND MY ENROLLED FAMILY MEMBERS 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 UNFORESEEN MEDICAL EMERGENCY AND THE TIME NEEDED TO CONTACT OUR PRIMARY CARE PHYSICIAN MAY MEAN PERMANENT DAMAGE TO OUR HEALTH. UNAUTHORIZED SERVICES THAT ARE NOT AN IMMEDIATE AND UNFORESEEN EMERGENCY, AS DESCRIBED ABOVE, RECEIVED FROM PHYSICIANS NOT PARTICIPATING WITH BCN WILL NOT BE COVERED.**

I authorize Blue Care of Michigan, Inc., BCN and 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 and for other purposes necessary for BCN and Blue Care of Michigan, Inc. 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 of Michigan, Inc. on my behalf for any services furnished to me by Blue Care of Michigan, Inc.

I agree to assign to BCN and Blue Care of Michigan, Inc. my entire right to recovery of the cost of hospital and medical services delivered by or paid for by BCN or Blue Care of Michigan, Inc. 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 I will be eligible for are described in the Personal Plus Certificate and that the Blue Care of Michigan, Inc. 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 I or my dependents receive from Blue Care of Michigan, Inc. during the 72 hours.

**I UNDERSTAND THAT I AND MY ENROLLED FAMILY MEMBERS WILL NOT BE COVERED FOR SIX MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE FOR ANY AND ALL CONDITIONS THAT 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, OR 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 coverage, or 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 I and any dependents included for coverage have satisfied the waiting period, provided there is no lapse in coverage when transferring to Personal Plus.

I certify the above information is true, correct, and complete to the best of my knowledge and belief. 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 family, denial of claims or cancellation.



Please Print Clearly

PERSONAL PLUS ENROLLMENT FORM

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

SUBSCRIBER SECTION 1

Table with columns: CIRCLE ONE, LAST NAME, FIRST NAME, MIDDLE, SEX, DATE OF BIRTH, SOCIAL SECURITY NO., \*C R O D E L E, PRIMARY CARE PHYSICIAN NAME - BCN/POS ONLY, LAST NAME, FIRST INITIAL, PHYSICIAN CODE, PHYSICIAN LOCATION, Seen in last 12 months or current patient (YES/NO)

\*Relationship Code, Previous Blue Care Network Affiliation, PCP Change Reasons - BCN/POS ONLY

If the permanent address of spouse or dependent is different from address in section one, please complete information below: Spouse/Dependent (Full name), Street Address, City, State, Zip Code

OTHER COVERAGE SECTION 2

Do you, your spouse or dependent(s) maintain other health coverage? Person Covered (Full name), Group, Policy Number, Carrier, Location

Are you, your spouse or any dependents listed in section 2 enrolled in Medicare? If Yes, attach a copy of Medicare card.

I have read and understand the conditions on the reverse side of this form. Subscriber Signature, Indicate name of employer or self-employed

If you or a dependent are covered under another health care policy, please explain why you are applying for this coverage?

Are you or any of your dependents who are applying for Personal Plus covered by: Medicare, Medicaid, Crippled Children

SIGNATURE SECTION 3

I have read and agreed to the terms on the back of this form. Type of Enrollment (Check one), Enrollee Signature, Date, BCN USE ONLY, Effective Date, Group I.D./Subgroup I.D./Class I.D., Date