Blue Cross Blue Shield of Michigan

MEMBERSHIP AND RECORD CHANGE

PLEASE PRINT OR TYPE

CONTRACT NUMBER	SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL
SERVICE CODE	SUBSCRIBER'S CURRENT ADDRESS ☐ CHECK HERE IF NEW ADDRESS	CITY / STATE	ZIP CODE
	GROUP NAME: MI BAC HEALTH	GROUP NO.: 58034 000	☐ OPEN ENROLLMENT

REQUEST FOR MEMBERSHIP CHANGE

ADD MEMBERS TO CONTRACT (ADDITIONS)

	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	SEX	DATE OCCURRED MO.	DAY	YR.	BIRTH DATE MO.	DAY	YR.
☐ MARRIAGE TO										
☐ BIRTH OF										
☐ STEPCHILD										
☐ CHILD BY LEGAL ADOPTION										
☐ CHILD BY LEGAL GUARDIANSHIP (WARD)										
☐ PRINCIPAL SUPPORT OF										
☐ DCCR ☐ CHANGE TO ☐ ADD				RELATIONSHIP						
☐ FAMILY CONTINUATION ☐ CHANGE TO ☐ ADD				RELATIONSHIP						
☐ SPONSORED DEPENDENT ☐ CHANGE TO ☐ ADD				RELATIONSHIP						
☐ DISABLED DEPENDENT				RELATIONSHIP						

DIAGNOSIS

DATE CONDITION DEVELOPED — MO. DAY YR.

PHYSICIAN'S SIGNATURE — MO. DAY YR.

FOR ANY CHILD NAMED ABOVE, IS THERE A COURT ORDER SAYING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? ☐ YES ☐ NO ☐ FATHER ☐ MOTHER IF YES, PLEASE ATTACH A COPY OF THE COURT ORDER.

REMOVE MEMBERS FROM CONTRACT (DELETIONS)

	LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER	DATE OCCURRED MO.	DAY	YR.
☐ DEATH OF DEPENDENT							
☐ DIVORCE FROM							
☐ MARRIAGE OF MINOR OR DEPENDENT							
☐ OTHER							

MEDICARE INFORMATION

IS ANY PERSON NAMED ABOVE ENTITLED TO MEDICARE? ☐ YES ☐ NO IF YES, COMPLETE AND ATTACH MEDICARE INFORMATION FORM # CN 3040

INSURANCE INFORMATION OTHER THAN MEDICARE (TRANSFER INFORMATION)

ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY ANOTHER BCBSM CONTRACT ? ☐ YES ☐ NO CONTRACT NO. GROUP NO.

ARE YOU OR ANYONE NAMED ON THIS FORM COVERED BY HEALTH INSURANCE FROM ANOTHER SOURCE? (FOR EXAMPLE, ANOTHER EMPLOYER, SPOUSE'S EMPLOYER, OR CHILD'S NATURAL PARENT) ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW

NAME OF INSURED	CONTRACT POLICY NO.
INSURANCE COMPANY AND ADDRESS	TERMINATION DATE / GROUP NO.

OTHER

☐ DEATH OF SUBSCRIBER OCCURRED ON MO. DAY YR. ☐ SEND DUPLICATE I.D. CARD ☐ CHANGE CONTRACT NO. TO:

☐ CHANGE SUBSCRIBER'S NAME TO LAST NAME FIRST NAME INITIAL

ADDITIONAL INFORMATION

VERIFICATION

I CERTIFY THAT I CAREFULLY AND FULLY READ THE IMPORTANT INFORMATION , THE STATEMENTS AND ANSWERS GIVEN ARE COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. NO INFORMATION REQUIRED TO BE GIVEN, EITHER EXPRESSLY OR BY IMPLICATION, HAS BEEN KNOWINGLY WITHHELD. I UNDERSTAND THAT BCBSM WILL RELY UPON THE COMPLETENESS AND TRUTHFULNESS OF THE INFORMATION GIVEN AND THE STATEMENTS MADE, THAT IF I HAVE MADE ANY FALSE STATEMENTS OR MISREPRESENTATIONS, OR HAVE FAILED TO DISCLOSE ANY MATERIAL FACT, BCBSM WILL BE ENTITLED TO DECLARE THE HEALTH CARE CONTRACT VOID AND REFUSE ALL ALLOWANCE OF THE BENEFITS TO ANY PERSON UNDER THE CONTRACT.

SUBSCRIBER'S SIGNATURE (DO NOT PRINT) DATE SIGNED

CN 0029 JUN 94 WHITE PLY: BLUE CROSS BLUE SHIELD CANARY PLY: EMPLOYER COPY