ECoS Forms — Instructions

New Subscriber Enrollment, Change of Status, or Primary Care Provider Selection

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

1 Select the appropriate forms

This packet includes three forms. See below to determine which form you should use.

New Subscriber Enrollment (page 3):

Use this form to enroll a subscriber in a new plan:

- During **open enrollment**
- As a **new hire**
- When **returning from layoff** or **rehired**
- Because subscriber has **lost eligibility** on another plan (loss of coverage). *If coverage is lost from an insurance carrier other than Blue Cross or BCN, a letter of credible coverage is required.*
- As a **retiree**
- When **surviving spouse** is eligible for enrollment as a new subscriber
- When a **spouse or dependent is enrolling in COBRA** as a new subscriber

Change of Status (page 5):

Use this form to make changes to an existing plan, such as:

- **Adding a dependen**t, including a spouse or child
- **Removing a dependent**, including a spouse or child
- **Transferring subscriber to a new division/ subgroup**
- **Changing or correcting personal information**, such as name, address, email or phone number.
- **Transferring an existing subscriber to a COBRA plan**

Primary Care Provider Selection (page 4)

Complete this form if:

- Subscriber is **enrolling in a BCN HMO plan or the Physicians Choice PPO plan**
- Subscriber, spouse or dependent is **changing PCP** — this can also be done conveniently online or in the Blue Cross app

2 Note the codes and documentation you will need

Use the codes below to complete sections B and D of the New Subscriber Enrollment or Change of Status forms.

Section B. Dependent information

Use codes below to indicate relationship.

Spouse **SP**
Domestic Partner* **DP**
Child *(by birth or adoption)* **N**
Stepchild **S**
Child adoption in process** **A**
Legal Guardianship** **L**
Disabled child*** **D**
Sponsored dependent* **SD**
Foster child **FC**
Court Order Coverage (QMCSO)** **C**
**Attach documentation*
***Attach court order*
****Attach provider statement*

Section C. Other health care coverage

Members with other health care coverage can contact insurer to find the original effective date.

If any members are enrolled in Medicare, please attach a copy of the Medicare card.

Section D. Health savings, health reimbursement and flexible spending account options

Do not complete for Blue Care Network members. If the plan offers HSA, HRA or FSA accounts and you are enrolling in one, use the codes below to indicate the account type you have selected.

HSA only **1000**
- HSA with limited purpose FSA **1070**
- HSA with dependent care FSA **1004**
- HSA with limited purpose FSA & dependent care FSA **1074**
- HSA with limited purpose HRA **1600**
- HSA Opt Out - High deductible plan without HSA **0000**

HRA only **0100**
- HRA with limited purpose FSA **0170**
- HRA with dependent care FSA **0104**
- HRA with limited purpose FSA & dependent care FSA **0174**
- HRA with health care FSA **0110**
- HRA with health care FSA & dependent care FSA **0114**

Health care FSA **0010**
- Dependent care FSA **0004**
- Health care and dependent care FSA **0014**
- PPO without Health care FSA **0000**

Section E. Employer/Group use only

New subscriber enrollment/COBRA: For a spouse or dependent applying to be the subscriber on a COBRA plan, the duration is always 36 months. **Change of status/COBRA:** For an existing subscriber changing to a COBRA plan, where the qualifying event is termination, COBRA duration is 18 months. In certain circumstances, if a disabled subscriber and non-disabled family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA coverage, for a total of 29 months.

3 Complete the forms and send to Membership and Billing — Be sure that:

- **Employer representative** has signed New Enrollment or Change of Status form.
- **Subscriber** has read the contract conditions on page 2 and signed where indicated on each form.
- **All required documentation is attached.**

For Blue Cross Blue Shield of Michigan

Mail:
Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610l
P.O. Box 312260
Detroit, MI 48231

Fax: 1-866-900-2619

Email:
GroupCustomerMembership@BCBSM.com

For Blue Care Network

Mail:
Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086

Fax: 1-877-218-1466

Email:
BCNGroupMembership@BCBSM.com

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Subscriber Agreement

Please read the following information before completing the attached forms. The information on these forms and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan.

I am applying for health care coverage with Blue Cross Blue Shield of Michigan or Blue Care Network, or I am modifying existing coverage for myself or enrolled family members. Coverage begins on the date determined by Blue Cross or BCN. When Blue Cross or BCN accepts my application or changes, my enrolled family members and I are bound by the terms of the Blue Cross or BCN certificates, riders, other coverage documents, policies and these forms. I understand that submitting false or misleading information or omitting material information on these forms may result in rejection of my changes or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my enrolled family members' eligibility for coverage when requested by Blue Cross or BCN.

Authorization: I appoint my employer or association to handle all matters of coverage. My employer may forward any agreed deductions for coverage from my wages. I am responsible for notifying my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements or death of someone enrolled on the plan. I authorize Blue Cross or BCN or my primary care provider to obtain the medical records relating to me and my enrolled family members needed to coordinate our medical care, administer my Blue Cross or BCN coverage and for other purposes necessary for Blue Cross or BCN to fulfill its contractual and statutory obligations.

Health Insurance Portability and Accountability Act: If I lose my eligibility for coverage, I may be entitled to special enrollment rights under HIPAA. Blue Cross or BCN reserves the right to request written verification of the date of the event and reason for loss of eligibility from my previous group or carrier. HIPAA special enrollment rights do not preempt a new hire waiting period, which must first be satisfied. Termination of employment may qualify for special enrollment rights, but voluntary terminations of other health care coverage do not.

Release of health care information: I acknowledge that Blue Cross or BCN requires me to provide my Social Security number. In applying for coverage, My enrolled family members and I agree to permit health care providers and others to release "protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996) to Blue Cross or BCN for administering our coverage. Upon my request, Blue Cross or BCN will tell me where the information was sent. If I have enrolled in a flexible spending account or health reimbursement arrangement through my employer, I authorize Blue Cross or BCN to provide claim information pertaining to me and my enrolled family members to the account administrator to facilitate reimbursement.

Group representative information: The group confirms that the status change requested complies with and is permitted under applicable state and federal law, including the Patient Protection and Affordable Care Act.

Blue Care Network only

My enrolled family members and I agree that all our medical services may be performed, prescribed, directed or authorized by our designated BCN primary care provider except in the case of an immediate and unforeseen medical emergency when the time needed to contact our primary care provider may mean permanent damage to our health. Unauthorized services that aren't an emergency as described above, received from non-BCN providers, won't be covered.

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

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

New Subscriber Enrollment

For BCN, or Physician Choice PPO, also complete page 4, Primary Care Provider Selection form

☐ Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

☐ Blue Care Network		
BCN group number	Subgroup number	Class number

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Employer representative signature SIGN

A. Subscriber information

☐ Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.	Marital status ☐ S ☐ M	Gender/Sex ☐ F ☐ M

Subscriber birth date	Home street address	City	State	ZIP code

County	Country - if other than USA	Primary telephone number ☐ Home ☐ Work ☐ Cell	Secondary telephone number ☐ Home ☐ Work ☐ Cell	Email

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	**Legal first name**	**M.I.**	**Gender/Sex**	**Birth date**	**Non-U.S. citizen**	**Social Security/TIN number** (required)	**Relationship** (see instructions for codes)
Spouse				☐ F ☐ M		☐		
Dep. 1				☐ F ☐ M		☐		
Dep. 2				☐ F ☐ M		☐		
Dep. 3				☐ F ☐ M		☐		
Dep. 4				☐ F ☐ M		☐		

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

Spouse or dependent (full name)	Street address	City	State	ZIP code

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No If yes, complete this section.	Person covered (full name)		☐ Check if this applies to all members on this contract	
	Employer or group name	Policy number	Insurer	Original effective date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No | If yes, check category: ☐ Over 65 and working ☐ Retiree ☐ Disabled ☐ ESRD | Medicare ID _____

☐ Medicare primary ☐ Blue Cross or BCN primary	☐ Subscriber ☐ Spouse ☐ Dependent: _____	Medicare A effective date	Medicare B effective date	Medicare D effective date

I have read and understand the conditions of this form	Subscriber signature SIGN	Date

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See page 1 instructions for product codes.

Select account option: ☐ HRA ☐ HSA ☐ FSA FSA goal amount _____ ☐ Opt out | Blue Cross product indicator code:

E. Employer/Group use only

Group name	Employer reference ID	Department ID	Benefit code	Plan code	Hire date	Effective date

Check coverage if applicable:
☐ Medical
☐ Vision
☐ Dental
☐ Pharmacy

Check enrollment type: ☐ Open enrollment ☐ New hire ☐ Rehire ☐ Return from layoff ☐ Surviving spouse ☐ Retiree

☐ Salary ☐ Hourly

☐ Loss of eligibility (prior coverage) Insurer's name (including Blue Cross & BCN) _____ Policy number _____

Contract holder _____ Termination date _____

☐ Full time ☐ Part time

☐ COBRA (36 mos.) Check reason: ☐ Termination ☐ Reduction of hours ☐ Divorce or legal separation ☐ Layoff ☐ Deceased subscriber ☐ Loss of dependent status

Previous contract number

Original qualifying date

Primary Care Provider Selection

Use this form to choose or change primary care providers for your BCBSM Physician Choice PPO or BCN HMO.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Choose a primary care provider at enrollment

If you are enrolling in Blue Cross Blue Shield of Michigan Physician Choice PPO or Blue Care Network, you must select a primary care provider for yourself and each person on your contract. If you have more than four dependents, use additional copies of this form.

- You can choose a single PCP for your entire family, or different PCPs for different family members.
- Only family or general practice providers can serve as a PCP for the entire family.
- You cannot choose a specialist as your PCP.
- Subscribers must provide their Social Security number, if they are U.S. citizens, or tax identification number (TIN) if they are non-U.S. citizens.

Change your primary care provider

You may also change your primary care provider by logging onto your bcbsm.com account or using the bcbsm.com mobile app.

- If using this form, all changes become effective two business days after we receive this form, unless you request a later effective date. You cannot select an earlier date.
- If you change your primary care provider while being treated by a specialist, your new primary care provider must reauthorize the treatment you're receiving. Your treatment may not be covered until that occurs. You may ask to change your primary care provider effective immediately by calling the Customer Service number on the back of your Blue Cross or BCN ID card.

☐ Non-U.S. citizen	Subscriber Social Security/TIN number (required)	BCN/Blue Cross group number	BCN subgroup/Blue Cross division number	BCN class number

Member Information						
	Member last name, first name	**Provider last name, first name**	**Provider's NPI#** *Can be found on* **bcbsm.com/find-a-doc**	**Provider address**	**If changing PCPs, list reason**	**Seen in the last 12 months?**
Subscriber						☐ Yes ☐ No
Spouse						☐ Yes ☐ No
Dep. 1						☐ Yes ☐ No
Dep. 2						☐ Yes ☐ No
Dep. 3						☐ Yes ☐ No
Dep. 4						☐ Yes ☐ No

Group/Employer name		Effective date of change:
I have read and understand the conditions of this form.	Subscriber signature SIGN	Signature date

Need information about available primary care providers?

Our website, bcbsm.com/find-a-doctor, provides the most current information on Blue Cross and BCN-affiliated primary care providers, including the NPI# required above. You can search for a family practice, general medicine, internal medicine, pediatrics, preventive medicine, city or hospital group.

For Blue Cross Blue Shield of Michigan:

Mail completed form to:

Blue Cross Blue Shield of Michigan
Membership and Billing – M.C. 610I
P.O. Box 312260
Detroit, MI 48231

Fax to **1-866-900-2619**

For Blue Care Network:

Mail completed form to:

Blue Care Network
Membership and Billing – M.C. C300
P.O. Box 5043
Southfield, MI 48086-5043

Fax to **1-877-218-1466**

Change of Status

Use this form to change personal information, add or delete a member, transfer division or transfer an existing subscriber to COBRA.

☐ Blue Cross Blue Shield of Michigan	
Blue Cross group number	Division

☐ Blue Care Network		
BCN group number	Subgroup number	Class Number

Employer representative signature SIGN

Date

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

A. Subscriber information — Fill in the fields marked with an asterisk only if the information has changed

☐ Non-U.S. citizen	Social Security /TIN number (required)	Subscriber legal last name	Subscriber legal first name	M.I.*	Marital status* ☐ S ☐ M	Gender/Sex* ☐ F ☐ M

Subscriber birth date	New home street address*	City*	State*	ZIP code*

County*	Country* - if other than USA	Primary telephone #* ☐ Home ☐ Work ☐ Cell	Secondary telephone #* ☐ Home ☐ Work ☐ Cell	Email*

B. Dependent information — List all family members to be covered. If you have more than four dependents, complete additional copies of this form.

	Legal last name	**Legal first name**	**M.I.**	**Gender/Sex**	**Birth Date**	**Non-U.S. citizen**	**Social Security/TIN number** (required)	**Relationship** (see instructions for codes)
Spouse ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 1 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 2 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 3 ☐ Add ☐ Delete				☐ F ☐ M		☐		
Dep. 4 ☐ Add ☐ Delete				☐ F ☐ M		☐		

If the permanent address of the spouse or dependent is different from the subscriber address above, please provide here:	Spouse or dependent (full name)	Home address	City	State	ZIP code

C. Other health care coverage (Coordination of benefits and Medicare information)

Do you, your spouse or dependents have other health care coverage? ☐ Yes ☐ No

If yes, complete this section.

Person covered (full name)		☐ Check if this applies to all members on this contract	
Employer or group name	Policy number	Insurer	Original effective date

Are any members listed enrolled in Medicare? ☐ Yes ☐ No | If yes, check category: ☐ Over 65 and working ☐ Retiree ☐ Disabled ☐ ESRD | Medicare ID _____

☐ Medicare primary ☐ Blue Cross or BCN primary	☐ Subscriber ☐ Spouse ☐ Dependent: _____	Medicare A effective date	Medicare B effective date	Medicare D effective date

I have read and understand the conditions of this form | Subscriber signature SIGN | Date

D. Health savings, health reimbursement and flexible spending account options - Blue Cross coverage only. See instructions for product selection codes

☐ HRA ☐ HSA ☐ FSA FSA goal amount _____ ☐ Opt out | Blue Cross product indicator code: | ☐ Add/Change ☐ Cancel

E. Employer/Group use only

Group name	Employer Reference ID	Department ID	Benefit code	Plan code

Type of change: ☐ Name ☐ Address ☐ Add member ☐ Benefit change

☐ Transfer: new division/subgroup _____ ☐ Subscriber COBRA enrollment: ☐ 18 ☐ 29 mos.

Loss of eligibility (prior coverage): ☐ Yes ☐ No If yes, complete below

Insurer (including Blue Cross & BCN) _____ Policy number _____

Contract holder _____ Termination date _____

Event date

Effective date

Cancellation: check type ☐ Contract ☐ Spouse ☐ Dependent

Check reason:

☐ Left employment ☐ Retired ☐ Death ☐ Divorce

☐ Other insurance ☐ Dependent over age ☐ Other

Last date of coverage _____

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話

ܐܸܢ ܐܲܚܬܘܢ، ܝܢ ܚܲܕ ܦܲܪܨܘܿܦܵܐ ܕܒܸܬ݂ܝܵܪܘܿܬ݂ܵܐ ܝܘܸܬ݂ܘܢ، ܣܢܝܼܩܝܼ ܠܗܘܿܢ ܗܲܝܪܵܐ، ܐܲܚܬܘܢ ܐܝܼܬ݂ܠܵܘܟ݂ܘܿܢ ܫܘܼܠܛܵܢܵܐ ܕܩܲܒܠܝܼܬ݂ܘܿܢ ܗܲܝܪܵܐ ܘܡܲܕܥܵܢܘܼܬ݂ܵܐ ܒܠܸܫܵܢܘܼܟ݂ܘܿܢ ܕܠܵܐ ܦܘܼܪܥܵܢܵܐ. ܠܗܲܡܙܲܡܬܵܐ ܥܲܡ ܚܲܕ ܡܬܲܪܓܡܵܢܵܐ، ܩܪܘܿܢ ܥܲܠ ܡܸܢܝܵܢܵܐ ܕܚܸܠܡܲܬ݂ ܥܲܠ ܣܛܪܵܐ ܕܟܲܪܬܘܿܟ݂ܘܿܢ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711,
fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697,
email: OCRComplaint@hhs.gov. Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.