Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MyBlue[SM] My Life, My Health Plan

Application for Waiver of Pre-Existing Waiting Period

Subscriber Name: ____

Contract Number: ______________________ Date of birth ________________

Your Blue Cross Blue Shield of Michigan individual coverage requires a 180-day pre-existing exclusion period during which coverage for pre-existing medical conditions is not available. Please complete this form and **attach your Certificate of Creditable Coverage (provided by your employer's previous carrier) and any supporting documentation (e.g. COBRA letter from employer)** so we may determine if your pre-existing exclusion period can be waived.

Yes **No**

Immediately preceding this application, I had at least 18 months of continuous health insurance coverage under one or more plans, and there was no more than a 62-day break in coverage between any plans.

My **most recent** health coverage was through a group (employer sponsored) health plan. I understand that even though health coverage might be provided through an association or other organization, it is considered to be individual coverage if it is not provided through an employer-sponsored group health plan.

Name, address and phone number of employer:

____

____

Coverage effective date: ____________ Termination date: ____________

I have elected **and** exhausted any COBRA coverage for which I was eligible. Please provide details below:

a) Does the employer employ at least 20 employees (full time and part time)?
   Yes No I don't know

b) Were you eligible to elect COBRA? Yes No I don't know

c) Did your employer notify you of your right to elect COBRA? Yes No

d) Was COBRA elected? Yes No

e) Time period/length of coverage (18 months, 29 months, 36 months)?
   Start date of coverage? ____________ End date? ____________

f) If coverage period was other than 18, 29 or 36 months, the reason COBRA coverage was terminated:
   - Employer no longer offered a health benefit plan
   - Cost
   - Eligible for other coverage
   - Other: ______________________________________

Analyst Code: __________

☐ ☐ I am eligible for group coverage (includes eligibility under spouse's employer) or eligible for Medicare or Medicaid.

☐ ☐ My prior coverage was terminated due to premium nonpayment or fraud.

☐ ☐ I no longer have group coverage.

If checked "yes", please indicate the reason for loss of previous coverage:
- ☐ Voluntarily cancelled
- ☐ No longer employed; date employment ended ____________________
- ☐ Employer no longer offered coverage
- ☐ Could not afford
- ☐ Other ____

I understand all of the above information will be used to determine if the pre-existing exclusion period should be waived. I also understand, should the pre-existing condition period be waived, and it is determined at a later date that the information provided was false or misrepresented, that I may be responsible to reimburse BCBSM for any claims incorrectly paid based upon this false or misleading information.

If someone else has completed any part of this form on my behalf, I have reviewed the information and confirm that it is accurate.

Name (please print): ____

Contract Number: ____

Signature: ____ Date: ________________

If you are not the member, please print your name and sign below. Check the box that describes your relationship to the member. **If you are not the parent of the member, please also attach proof of your relationship** (e.g. Power of Attorney personal representative documentation).

Name (please print): ____

Signature: ____ Date: ________________

☐ Parent of minor child ☐ Legal guardian ☐ Power of Attorney ☐ Executor
☐ Other ____

Return to: Blue Cross Blue Shield of MI
600 E. Lafayette Blvd.
Detroit, MI 48226
Mail Code BP210

Fax: 313-463-6443
Customer Service 1-800-848-5101

Analyst Code: _____________