Blue Care Network of Michigan

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

PO Box 44257
Detroit MI 48244-0257
Fax: 1-877-218-1466

BCN 65℠ Nongroup Enrollment/Change Form

Information about You

Last Name	First Name	M.I.	Medicare Number	☐ Male ☐ Female	Date of Birth	Marital Status ☐S ☐M
Street Address					Home Phone	
City	State	ZIP Code	County		Work Phone	
Employer	Primary Care Physician Name			Current Patient ☐Yes ☐No	Physician ID Number **P**	

Information about Your Spouse (if enrolling with you)

Last Name	First Name	M.I.	Medicare Number	☐ Male ☐ Female	Date of Birth
Street Address					Home Phone
City	State	ZIP Code	County		Work Phone
Employer	Primary Care Physician Name			Current Patient ☐Yes ☐No	Physician ID Number **P**

Medicare Information
Please print information exactly as it appears on your Medicare health insurance card(s).

Applicant
Health Insurance
Medicare Number Act

Medicare Claim Number

__ __ __ __-__ __-__ __ __ __-__ __

Is entitled to — Effective Date

HOSPITAL (PART A) ___ - ___ - ___

MEDICAL (PART B) ___ - ___ - ___

Spouse
Health Insurance
Medicare Number Act

Medicare Claim Number

__ __ __ __ - __ __-__ __ __ __-__ __

Is entitled to — Effective Date

HOSPITAL (PART A) ___ - ___ - ___

MEDICAL (PART B) ___ - ___ - ___

BCN 65 Enrollment

☐ Applicant, new enrollment

☐ Spouse, new enrollment

Requested effective date _____

You may request an effective date, subject to BCN approval.

Do not send payment with your application. BCN will send an invoice after enrollment.

BCN 65 is not a Medicare supplemental product. It may not fit all the gaps in Medicare, and it may duplicate some Medicare benefits. If you are eligible for Medicare, review your coverage choices online at **Medicare.gov**. If you decide to buy BCN 65, be sure you understand what it covers, what it does not cover and whether it duplicates coverage you already have.

Information Required by Michigan Law

Are you or your spouse currently a member of Blue Care Network?	☐ Yes	☐ No
Do you have health insurance or coverage through a current or former employer?	☐ Yes	☐ No
If yes, carrier name: _____ Policy number: _____		
Does your spouse have health insurance or coverage through a current or former employer?	☐ Yes	☐ No
If yes, carrier name: _____ Policy number: _____		
Do you have Medicaid coverage? (state assistance)	☐ Yes	☐ No
Does your spouse have Medicaid coverage? (state assistance)	☐ Yes	☐ No

Conditions of Coverage

- I am applying for Blue Care Network BCN 65 coverage. I certify that I am enrolled in both Part A and Part B of Medicare, that all requirements of eligibility are met and that the information I have given on this application is true and correct.
- I authorize Blue Care Network to obtain from providers of service and hospitals the medical records relating to me that are necessary to the administration of my contract with Blue Care Network.
- I assign Blue Care Network my entire right of recovery of the cost of hospital and medical services delivered by or paid for by Blue Care Network against any person or organization 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 understand that the benefits I will be eligible for are described in the BCN 65 Certificate and that the Blue Care Network marketing materials are only a summary.
- I certify that 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 denial of claims or cancellation.

If your application is received...	**Your coverage is effective...**
On or before the last day of the month	The first day of the following month (Example: Your application is received June 28; your coverage is effective July 1.)

I have read and agreed to the terms on this form. I understand that approval of this application and coverage effective date will be determined by Blue Care Network and is subject to timely payment at the applicable rates. If I cancel within 30 days of the effective date of this coverage, I will be entitled to a refund of my previous premium payment, less **the reasonable costs for any health services paid by Blue Care Network during that time period. I will be responsible for payment of reasonable fees for any health care services received.**

Subscriber Signature: _____ Date: _____

Spouse Signature: _____ Date: _____