2027 Membership Changes
Individual and Family Plans

Blue Care Network of Michigan

Use this form to update your information, change your current plan because of a qualifying life event, or terminate coverage.

If you enrolled in your plan through the Health Insurance Marketplace (your enrollee ID starts with XYW), you must contact them directly at 1-800-318-2596 to report all membership changes.

A qualifying life event – **listed below in Section D** – allows you to make changes to your current coverage, generally, within 60 days of the event. To complete your change request, some events require documentation to confirm the event. If you have any questions, please call the Customer Service number on the back of your ID card.

A Enrollee information

First name	Last name	MI	Enrollee ID *(number on your card beginning with XYG)*

B Apply changes to *(check plan(s) to be affected and fill out group number from each card)*

☐ Medical _____ ☐ Dental _____ ☐ Vision _____

C Enrollee changes *(check and fill out all that apply)*

☐ **Enrollee name change**	First	Last	MI
☐ **Date of birth change**	(mm/dd/yyyy)		

☐ **Residential address change – A residential address change may result in a change in premium rate.**
A change of address requires a copy of proof of residency *(driver's license, rental lease or mortgage agreement)*

Address	City	State	ZIP code

☐ **Alternate mailing address** *(an alternate address is for routing of mail only)*

Address	City	State	ZIP code

☐ **Telephone number change**	Home	Cell
☐ **Email address change**	Email address	

D Qualifying life event *(check event below and fill out all information for the dependent(s) you are adding or removing).*

When submitting completed form, be sure to attach copies of the required documentation for the checked life event. Refer to **bcbsm.com/documents** for full list of acceptable documentation.

Date of event (mm/dd/yyyy)

☐ **Marriage** *(marriage license required)*
☐ **Birth** *(birth certificate or verification of birth required)*
☐ **Adoption** *(legal guardianship, foster parenthood, adoption or replacement for adoption documentation required)*
☐ **Loss of coverage** *(prior coverage documentation required)*
☐ **Death** *(copy of death certificate required)*
☐ **Divorce** *(divorce decree or legal separation documentation required)*
☐ **Enrolled in Medicare** *(proof of coverage with effective date required)*
☐ **Other** _____

Dependent information (only dependent(s) you are adding or removing)

☐ **ADD dependent** ☐ **REMOVE dependent**

First name	Last name	MI	Gender	Tobacco user* *(required)*
			☐ Male ☐ Female	☐ Yes ☐ No

Date of birth	Social Security number	Relationship to subscriber

☐ **ADD dependent** ☐ **REMOVE dependent**

First name	Last name	MI	Gender	Tobacco user* *(required)*
			☐ Male ☐ Female	☐ Yes ☐ No

Date of birth	Social Security number	Relationship to subscriber

☐ **ADD dependent** ☐ **REMOVE dependent**

First name	Last name	MI	Gender	Tobacco user* *(required)*
			☐ Male ☐ Female	☐ Yes ☐ No

Date of birth	Social Security number	Relationship to subscriber

During the past six months, has the new dependent age 21 and older been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?* ***Blue Cross reserves the right to verify tobacco use and to adjust your premium accordingly.* *Please see Terms and Conditions for additional information at* ***bcbsm.com****.*

*** By signing this change of status form, if you have dependents under the age of 19, you attest to being compliant with ACA and Essential Health Benefits requirements by having purchased a certified Pediatric Dental plan either with BCBSM or with another insurance carrier.*

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross Blue Shield Association.

Enrollee ID _____

E 2027 medical plan *(check one below)*

*Coverage varies by plan type. Go to **bcbsm.com** to learn more.*

☐ KEEP CURRENT PLAN _____

Local HMO	Select HMO	Preferred HMO
☐ Blue Cross® Local HMO Gold Standard	☐ Blue Cross® Select HMO Gold Standard	☐ Blue Cross® Preferred HMO Gold Standard
☐ Blue Cross® Local HMO Gold Saver	☐ Blue Cross® Select HMO Gold Saver	☐ Blue Cross® Preferred HMO Gold Saver
☐ Blue Cross® Local HMO Gold Plus	☐ Blue Cross® Select HMO Gold Plus	☐ Blue Cross® Preferred HMO Gold Plus
☐ Blue Cross® Local HMO Silver	☐ Blue Cross® Select HMO Silver	☐ Blue Cross® Preferred HMO Silver
☐ Blue Cross® Local HMO Silver HSA	☐ Blue Cross® Select HMO Silver Standard	☐ Blue Cross® Preferred HMO Silver Standard
☐ Blue Cross® Local HMO Silver Standard	☐ Blue Cross® Select HMO Silver HSA	☐ Blue Cross® Preferred HMO Silver HSA
☐ Blue Cross® Local HMO Silver Saver	☐ Blue Cross® Select HMO Silver Saver	☐ Blue Cross® Preferred HMO Silver Saver
☐ Blue Cross® Local HMO Silver Plus	☐ Blue Cross® Select HMO Silver Plus	☐ Blue Cross® Preferred HMO Silver Plus
☐ Blue Cross® Local HMO Bronze Standard HSA	☐ Blue Cross® Select HMO Bronze Standard HSA	☐ Blue Cross® Preferred HMO Bronze Standard HSA
☐ Blue Cross® Local HMO Bronze Saver HSA	☐ Blue Cross® Select HMO Bronze Saver HSA	☐ Blue Cross® Preferred HMO Bronze Saver HSA
☐ Blue Cross® Local HMO Bronze Plus HSA	☐ Blue Cross® Select HMO Bronze Plus HSA	☐ Blue Cross® Preferred HMO Bronze Plus HSA
☐ Blue Cross® Local HMO Catastrophic HSA	☐ Blue Cross® Select HMO Catastrophic HSA	☐ Blue Cross® Preferred HMO Catastrophic HSA

*Health Savings Account (HSA) provided by HealthEquity®. There is no charge per month for our HSA. To learn more, visit **bcbsm.com/hsa**.*

F Voluntary contract termination *(includes enrollee and all dependents)*

☐ **Please terminate this contract** *(for plan(s) selected in Section B).* Termination date will be effective as of the receipt of this request, unless your specify a future termination date.

Without a qualifying event to enroll in coverage, termination of a policy may not allow you to enroll in another plan until the next open enrollment period, which starts in the 4th quarter of each year.

Requested date (mm/dd/yyyy)

G Authorization and signature *(required)*

*I understand the summary of benefits and coverage related to the coverage change requested is available at **bcbsm.com/sbc**. I understand the summary of benefits and coverage is not a contract and that it provides only a general overview of coverage information and if there is any difference or discrepancy between the summary of benefits and my applicable plan document (including certificates and riders), the plan document will control.*

*I consent to delivery of the summary of benefits and coverage electronically on the website. I understand a paper copy is also available, free of charge, by calling Blue Care Network of Michigan toll-free at **1-888-227-2345**. I verify that the qualifying life event information provided on this form is true and correct to the best of my knowledge.*

Blue Cross reserves the right to require additional documentation as proof of the event.

Signature of subscriber	Date

IMPORTANT: Please read the form carefully and be sure you have:

- Included all necessary information
- Attached copies of required documentation as specified in Sections C and D

Mail this form along with required supporting documentation to:

Blue Care Network of Michigan
P.O. Box 44257, Mail Code J205
Detroit, MI 48244-0257

or fax to: 1-877-218-1466

DO NOT include premium payments.
Premium payments cannot be processed at this address.

Internal use only *(Agent or Health Plan Advisor)*

As the Blue Cross Blue Shield of Michigan and Blue Care Network appointed Agent of Record for the above member and his or her corresponding policy, or as a Blue Cross Blue Shield of Michigan and Blue Care Network certified Health Plan Advisor, I hereby acknowledge and confirm that the member listed above has granted me the authority to transact the changes or actions indicated on this form. I have made the member aware of all potential impacts to rates, benefits and eligibility that may result from these changes. I verify that the information provided on this form is true and correct to the best of my knowledge.

Agent/HPA name	Blue Cross 5 digit agent ID
Agent/HPA signature	Date

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