Membership Changes

Individual and family plans

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

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

If you enrolled in your plan through the Health Insurance Marketplace (your enrollee ID starts with XYW), you must call the Marketplace directly at 1-800-318-2596 to make 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 request, some events require documentation to confirm them. If you have any questions, call the Customer Service number on the back of your Blue Care Network member ID card.

A Enrollee information

First name__________ **Last name**__________ **M.I.**____

Enrollee ID *(number on your card beginning with XYB)* __________

B Apply changes to *(check each type of coverage you're changing 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**__________ **M.I.** ____

☐ **Date of birth change** *(MM/DD/YYYY)* __________ ☐ **Social Security number** __________

☐ **Residential address change**

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

Address__________

City__________ **State**______ **ZIP**______

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

Address__________

City__________ **State**______ **ZIP**______

☐ **Telephone number change**

Home__________ **Cell** __________

D Qualifying life event *(Check event below and fill out all information for the dependents you're adding or removing.)* When submitting a completed form, attach copies of the required documentation for the checked life event. Refer to **bcbsm.com/documents** for a 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 placement for adoption documentation required)*

☐ **Loss of coverage** *(prior coverage documentation required)*

☐ **Death** *(death certificate required)*

☐ **Divorce** *(divorce decree or legal separation documentation required)*

☐ **Enrolled in Medicare**

☐ **Other** __________

Dependent information[1] *(only dependents you are adding or removing)*

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

First name__________ **Last name**__________ **M.I.**____

Date of birth *(MM/DD/YYYY)*__________ **Social Security number** __________

Relationship to subscriber__________ **Gender (M/F)**____ **Tobacco user**[2] (**required** yes or no)______

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

First name__________ **Last name**__________ **M.I.**____

Date of birth *(MM/DD/YYYY)*__________ **Social Security number**__________

Relationship to subscriber__________ **Gender (M/F)**____ **Tobacco user**[2] (**required** yes or no)______

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

First name__________ **Last name**__________ **M.I.**____

Date of birth *(MM/DD/YYYY)* __________ **Social Security number** __________

Relationship to subscriber __________ **Gender (M/F)**____ **Tobacco user**[2] (**required** yes or no)______

1 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 Blue Cross Blue Shield of Michigan or with another company.

2 During the past six months, has the new dependent age18 or 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.**

Enrollee ID *(from Section A)* _____

E 2024 Medical plan *(check one below)*

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

☐ **Keep current plan:** _____

Metro Detroit HMO (BCN plans)

Silver

- ☐ Blue Cross® Metro Detroit HMO **Silver Extra**
- ☐ Blue Cross® Metro Detroit HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Metro Detroit HMO **Bronze**
- ☐ Blue Cross® Metro Detroit HMO **Bronze Saver HSA** (available off-marketplace only)
- ☐ Blue Cross® Metro Detroit HMO **Bronze Extra**

To learn about the Metro Detroit HMO network, and to see if your doctor is in network, visit bcbsm.com/marketplace/metro-detroit-hmo/.

Local HMO (BCN plans)

Silver

- ☐ Blue Cross® Local HMO **Silver Extra**
- ☐ Blue Cross® Local HMO **Silver Saver**
- ☐ Blue Cross® Local HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Local HMO **Bronze Saver HSA** (available off-marketplace only)
- ☐ Blue Cross® Local HMO **Bronze Secure**
- ☐ Blue Cross® Local HMO **Bronze Extra**

To learn about the Local HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/local-hmo/**.

Select HMO (BCN plans)

Silver

- ☐ Blue Cross® Select HMO **Silver Extra**
- ☐ Blue Cross® Select HMO **Silver**
- ☐ Blue Cross® Select HMO **Silver Saver**
- ☐ Blue Cross® Select HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Select HMO **Bronze**
- ☐ Blue Cross® Select HMO **Bronze Saver HSA**
- ☐ Blue Cross® Select HMO **Bronze Secure** (available in Select Network, except for Wayne, Oakland and Macomb counties)
- ☐ Blue Cross® Select HMO **Bronze Extra**

Catastrophic

- ☐ Blue Cross® Select HMO **Value** (under age 30 before the plan effective date)

To learn about the Select HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/select-hmo/**.

Preferred HMO (BCN plans)

Gold

- ☐ Blue Cross® Preferred HMO **Gold**
- ☐ Blue Cross® Preferred HMO **Gold Extra**

Silver

- ☐ Blue Cross® Preferred HMO **Silver Extra**
- ☐ Blue Cross® Preferred HMO **Silver** (available in the lower peninsula, except for Wayne, Oakland and Macomb counties)
- ☐ Blue Cross® Preferred HMO **Silver Saver**
- ☐ Blue Cross® Preferred HMO **Silver Off Marketplace**
- ☐ Blue Cross® Preferred HMO **Virtual Primary Care Silver** (available in the lower peninsula, except for the Select Network – 20 counties)

Bronze

- ☐ Blue Cross® Preferred HMO **Bronze** (available statewide, except for the Select Network – 20 counties)
- ☐ Blue Cross® Preferred HMO **Bronze Saver HSA** (available statewide, except for Wayne, Oakland and Macomb counties)
- ☐ Blue Cross® Preferred HMO **Bronze Extra**
- ☐ Blue Cross® Preferred HMO **Bronze Secure** (available statewide, except for the Select Network – 20 counties)
- ☐ Blue Cross® Preferred HMO **Virtual Primary Care Bronze** (available statewide, except for the Select Network – 20 counties)

Catastrophic

- ☐ Blue Cross® Preferred HMO **Value** (under age 30 before the plan effective date and available statewide, except for the Select Network – 20 counties)

To learn about the Preferred HMO network, and to see if your doctor is in network, visit bcbsm.com/marketplace/preferred-hmo.

F Voluntary contract termination

Please terminate this contract (*for plan(s) selected in Section A*)
Cancellation date will be the date we received this request, unless you specify a future cancellation date.

Requested date: _____
Without a qualifying event to enroll in coverage, cancellation 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.

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

Sign here _____ **Date** _____

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 and the required supporting documentation to:
Blue Care Network of Michigan
P.O. Box 5043
Southfield, MI 48086-5043
Or fax to:**1-877-218-1466**

Do not include premium payments.
Premium payments can't be processed at this address.

SECTION C required documentation
A change of address requires proof of residency *(driver's license, rental lease or mortgage agreement)*

SECTION D required documentation
- **Marriage** *(marriage license)*
- **Birth** *(birth certificate or verification of birth)*
- **Adoption** *(legal guardianship, foster parenthood, adoption or placement for adoption documentation)*
- **Death** *(death certificate)*
- **Divorce***(divorce decree or legal separation documentation)*

Internal use only*(agent orhealth 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 or advisor name_____ **Blue Cross five-digit agent ID**_____

Agent or advisor signature

Sign here _____ **Date** _____

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, or 877-469-2583, TTY: 711 if you are not already a member.

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, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

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، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

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；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە هاوکاری دەکەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە کە لەسەر پشتەوەی کارتەکەتە، یان 877-469-2583 TTY:711، ئەگەر ئەندام نیت.

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, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

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, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

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 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 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 বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

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 lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

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 oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

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 o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

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 (メンバーでない方は877-469-2583, TTY: 711) 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 номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

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, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

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, or 877-469-2583, TTY: 711 if you are not already a member. 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*.