Blue Cross Blue Shield Blue Care Network of Michigan

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

# CA Choice Enrollment

☐ BCBSM ☐ BCN

| BCBSM Group | BCN Group ID | Subscriber signature | Date |
|---|---|---|---|
| | | | |

## Subscriber information

| Subscriber Social Security number (Required) | Subscriber last name | Subscriber first name | MI | Marital status | Gender | Subscriber birth date |
|---|---|---|---|---|---|---|
| | | | | ☐ S ☐ M | ☐ M ☐ F | |

| Home street address | City | State | ZIP Code | E-mail |
|---|---|---|---|---|
| | | | | |

| County | Country – if other than USA | Primary phone ☐ Home ☐ Work ☐ Cell | Secondary phone ☐ Home ☐ Work ☐ Cell |
|---|---|---|---|
| | | | |

List all persons to be covered:

| | Last name | First name | MI | Gender | Date of birth | Social Security number | Relationship (See instructions on back) |
|---|---|---|---|---|---|---|---|
| Spouse | | | | ☐M ☐F | | | |
| Dep. 1 | | | | ☐M ☐F | | | |
| Dep. 2 | | | | ☐M ☐F | | | |
| Dep. 3 | | | | ☐M ☐F | | | |
| Dep. 4 | | | | ☐M ☐F | | | |

Are any listed members enrolled in Medicare? ☐ No ☐ Yes If yes, check reason category ☐ Working aged ☐ Retired ☐ Disabled ☐ ESRD

Medicare ID

☐ Medicare primary ☐ BCBSM or BCN primary

Medicare A effective date: _____

Medicare B effective date: _____

Medicare D effective date: _____

## Instructions for completing CA Choice Enrollment

- Indicate if enrolling in BCBSM or BCN
- Enter BCBSM group or BCN group number, subgroup number and BCN class number.

**Subscriber information:**

- Enter subscriber Social Security number (required if 45 years of age or older). Enter subscriber last name, subscriber first name and middle initial. Indicate whether single or married, male or female. Enter subscriber date of birth.
- Enter home address beginning with street address, city, state and ZIP code. Enter e-mail address for member outreach (i.e. health and wellness).
- Enter county name for home address, country name (if other than USA). Enter primary and secondary phone number and indicate if home, work or cell.
- List all persons currently enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if needed for all your dependents.
- Enter last name, first name, middle initial, male or female, date of birth, Social Security number (required if 45 years of age or older) and relationship code (see below).

Relationship codes:

| | | |
|---|---|---|
| N - Child (by birth or adoption) | A - Child adoption in process ** | C - Court order coverage (QMCSO) ** |
| S - Stepchild | L - Legal guardianship ** | D - Disabled child *** |
| P - Principal support | SD - Sponsored dependent * | M - Medicare |

* = Attach documentation ** = Attach court order *** = Attach physician statement

- Enter the spouse's or dependent's permanent address if different from the address indicated above.

Send completed forms to:

For Blue Cross Blue Shield of Michigan

Membership and Billing/CA Choice Enrollment- MC J 202
Blue Cross Blue Shield of Michigan
P.O. Box 312260
Detroit, MI 48231-2260
Fax: 1-866-900-2619

For Blue Care Network

Membership and Billing/CA Choice Enrollment- MC J 207
Blue Care Network
P.O. Box 44257
Detroit, MI 48244-0257
Fax: 1-877-218-1466

Email: CAChoiceEnrollment@bcbsm.com