

Application for Coverage

Individuals and Families
(Off Marketplace Only)

This application may be used for 2026 individual and family coverage through either Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), depending on which medical plan you choose. Dental plans, dental with vision, and adult vision plans are only offered through BCBSM, but can be paired with BCBSM or BCN medical plans.

Print in black or blue ink. **Complete all fields unless otherwise noted.** Review your application for accuracy, then sign and date. Your information will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website at bcbsm.com/index/common/important-information/privacy-practices.html#Privacy.

If you'd like to apply for a subsidy or tax credit, are age 30 or older and would like to check your eligibility for a hardship exemption to enroll in a Value Plan or are Native American and eligible for additional cost-sharing benefits, contact us at 1-888-899-3012 or your Blue Cross Agent.

To get individual medical, dental, dental with vision, or adult vision coverage, you must be a Michigan resident when your coverage starts and intend to reside in Michigan. If you're enrolled in Medicare, you're not eligible for individual medical coverage.

Section I: Coverage and Enrollment

Who will be covered by this plan?

One adult (individual plan)

Multiple people (family plan)

One child only (be sure to complete the "child only coverage" section on Page 3)

Why are you applying?

Annual Open Enrollment November 1 to January 15, 2026

I have a qualifying event, loss of coverage, or am planning to move to Michigan

Adult only Vision coverage **(doesn't require a qualifying event)**

Dental or Dental with Vision **(doesn't require a qualifying event)**

Have you had individual or employer-sponsored medical coverage in the past 60 days?

Yes

No

If you had BCBSM or BCN coverage, indicate the 9-digit enrollee ID found on your BCBSM/BCN member ID card. If you don't have your enrollee ID, please enter 000000000: _____.

Note: The availability of continuous coverage depends on your event, event date and application date. Proof of employer coverage is required if you are or were an employer-sponsored member seeking continuous coverage due to loss of employer-sponsored coverage or death of the primary policy holder.

Date of qualifying life event:

_____. Your coverage start date will be assigned after we receive your application.

Will you use a reimbursement arrangement?

Are any applicants purchasing this plan using an Individual Coverage Health Reimbursement Arrangement (ICHRA)?

Yes

No

If yes, please complete the section below.

Effective date of the ICHRA

Monthly contribution amount

Employer name

Internal use only:

Original effective date requested _____ Application ID _____

The below list of qualifying events applies to 2026 plan year coverage. If seeking coverage for the 2025 plan year based on a qualifying life event, contact us at 1-888-899-3012 or your Blue Cross agent. For a list of supporting proof by event, please visit bcbsm.com/index/health-insurance-help/faqs/topics/buying-insurance/qualifying-events-special-enrollment/documents.html. Your event must have taken place within 60 days of your application date to be considered for coverage. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable.

Please select the event that applies to you below.

(Note: to obtain coverage, you must submit supporting documentation of the event you select.)

Birth, adoption

Legal guardianship

Gaining or becoming a dependent due to a child support order, foster child placement or other court order

Marriage

Loss of employer-sponsored group coverage. *Examples: Job loss, employer ended health coverage or terminated contributions toward health coverage or reduced work hours (below the minimum necessary to maintain coverage).*

Divorce or legal separation

Death of policy holder

Dependent aging off or loss of coverage through a parent or legal guardian

Involuntary loss from Medicaid or Children's Health Insurance Program (CHIP)

Newly ineligible for Advance Premium Tax Credit or Cost Sharing Reduction

Loss of student health plan, discontinued or involuntary loss of individual qualified health plan

Policy holder became eligible for and enrolled in Medicare

Exhaustion of COBRA benefits

Moved out of plan coverage area with loss of coverage

– *Includes moves from outside the country or U.S. territory without loss of coverage*

Gained new access to Individual HRA or QSEHRA

Gained access to a new plan as a result of a permanent move

Events for Dental Only: Loss of Marketplace Dental or Newly eligible for Medicare part B

Other event: _____

Include supporting documentation with your application, or promptly send to:

Email: IBUenrollment@bcbsm.com

Fax: 1-866-392-7528

Individual Membership and Billing

Blue Cross Blue Shield of Michigan

600 E. Lafayette Blvd., Mail Code J200

Detroit, MI 48226-2998

Put "QLE Supporting Documents" in the subject line of your email. Your supporting documentation must include the primary applicant's first name, last name, date of birth, phone number, and application submission date.

Please tell us about the main person applying for this plan. All of your information will be kept confidential and only used for this application.									
Last name		First name		M.I.	Suffix	Social Security or personal tax ID number		Are you a U.S. citizen or legally present in the U.S.? Yes No	
Residential address (can't be a P.O. Box)		City				State	ZIP code	County	
Billing address (if different than above)		City				State	ZIP code	County	
Email (required)		Primary phone number		Type:	Fax	Alternate phone number		Type:	Fax
				Home	Cell			Home	Cell
				Work	Other			Work	Other
Gender Male Female	Date of birth (if child only coverage, parent or legal guardian must provide signature).		Current resident or intend to reside in Michigan on the effective date of this coverage? Yes No			During the past six months, have you used tobacco or nicotine in any form four or more times per week? Yes No			
<i>*BCBSM/BCN reserves the right to verify tobacco or nicotine use and to adjust your premium accordingly.</i>									
Information about your spouse who is applying for this plan									
Last name		First name		M.I.	Suffix	Social Security or personal tax ID number		Are you a U.S. citizen or legally present in the U.S.? Yes No	
Gender Male Female	Date of birth		Current resident or intend to reside in Michigan on the effective date of this coverage? Yes No			During the past six months, have you used tobacco or nicotine in any form four or more times per week? Yes No			
<i>*BCBSM/BCN reserves the right to verify tobacco or nicotine use and to adjust your premium accordingly.</i>									
Information about your dependent children (under age 26 on the policy effective date) who are applying for this plan									
Last name	First name	M.I.	Date of birth	Social Security or personal tax ID number (age one and older required, or under age one if available)		Gender	Relationship*		
						Male Female			
						Male Female			
						Male Female			
						Male Female			
						Male Female			
						Male Female			
						Male Female			
						Male Female			
During the past six months, have any of the listed dependents used tobacco or nicotine in any form? Yes No If yes, who? _____									
<i>*Dependent relationship codes (we reserve the right to audit documentation for all codes except "N")</i> N – Child (by birth or adoption) P – Principally supported child A – Child adoption in progress S - Stepchild C – Court ordered coverage L – Legal guardianship D – Disabled child									
Child only coverage									
Please complete this section if applying for child only coverage. Child only coverage is available for persons under age 21 on the policy effective date. A separate application is necessary for each child.									
Child's last name	Child's first name	M.I.	Suffix	Child's Social Security or personal tax ID number (age one and older required, or under age one if available)		Child's date of birth	Male Female	U.S. citizen or legally present in the U.S.? Yes No	
Child's residential address (Cannot be a P.O. Box)		City			State	ZIP code	County		
Legal guardian's name		Legal guardian's primary phone number		Legal guardian's email			Legal guardian's SSN (optional – used to create member online account)		
Legal guardian's address		City				State	ZIP code		

Section II: Medical Plan Selection

Your network of affiliated doctors and hospitals may be different based on the product you choose. Please visit bcbsm.com/find-a-doctor, or consult your coverage documents, or a Blue Cross agent for specific network details. The BCN HMO medical plans are managed-care plans; your care will be coordinated by a primary care physician that you select upon enrollment.

Pediatric vision benefits are included in all medical plans.

To view the BCBSM prescription drug formulary, visit BCBSM/PPO: bcbsm.com/2026-select-ppo-druglist.

To view the BCN prescription drug formulary, visit BCN/HMO: bcbsm.com/2026-select-hmo-druglist.

Premiums are charged for the subscriber, spouse and all adult children age 21 and older, and for the three oldest dependent children under age 21. Child only policies are available on all plans below.

Please select your medical plan from the list below. For plan details and availability, visit bcbsm.com/myblue.

Local HMO (BCN Plans)	Preferred HMO (BCN Plans)
Silver - Blue Cross® Local HMO Silver Extra - Blue Cross® Local HMO Silver Saver - Blue Cross® Local HMO Silver Secure (available off-marketplace only) - Blue Cross® Local HMO Silver Plus (available off-marketplace only) - Blue Cross® Local HMO Silver HSA (available off-marketplace only) Bronze - Blue Cross® Local HMO Bronze Extra - Blue Cross® Local HMO Bronze Saver HSA (available off-marketplace only) - Blue Cross® Local HMO Bronze Secure - Blue Cross® Local HMO Bronze Plus (available off-marketplace only) - Blue Cross® Local HMO Bronze HSA (available off-marketplace only) To learn about the Local HMO network, and to see if your doctor is in network, visit bcbsm.com/marketplace/local-hmo/.	Gold - Blue Cross® Preferred HMO Gold - Blue Cross® Preferred HMO Gold Extra Silver - Blue Cross® Preferred HMO Silver (available in the lower peninsula) - Blue Cross® Preferred HMO Silver Extra - Blue Cross® Preferred HMO Silver Saver (available statewide, except for Wayne, Oakland and Macomb counties) - Blue Cross® Preferred HMO Silver Secure (available off-marketplace only) - Blue Cross® Preferred HMO Silver Plus (available off-marketplace only) - Blue Cross® Preferred HMO Silver HSA (available off-marketplace only) Bronze - Blue Cross® Preferred HMO Bronze Extra - Blue Cross® Preferred HMO Bronze Saver HSA - Blue Cross® Preferred HMO Bronze Secure (available statewide, except for Wayne, Oakland and Macomb counties) - Blue Cross® Preferred HMO Bronze Plus (available off-marketplace only) - Blue Cross® Preferred HMO Bronze HSA (available off-marketplace only) Catastrophic - Blue Cross® Preferred HMO Value (under age 30 before the plan effective date and available statewide, except for the Select Network – 31 counties) To learn about the Preferred HMO network, and to see if your doctor is in network, visit bcbsm.com/marketplace/preferred-hmo/.
Select HMO (BCN Plans) Silver - Blue Cross® Select HMO Silver - Blue Cross® Select HMO Silver Extra - Blue Cross® Select HMO Silver Saver - Blue Cross® Select HMO Silver Secure (available off-marketplace only) - Blue Cross® Select HMO Silver Plus (available off-marketplace only) - Blue Cross® Select HMO Silver HSA (available off-marketplace only) Bronze - Blue Cross® Select HMO Bronze Extra - Blue Cross® Select HMO Bronze Saver HSA - Blue Cross® Select HMO Bronze Secure - Blue Cross® Select HMO Bronze Plus (available off-marketplace only) - Blue Cross® Select HMO Bronze HSA (available off-marketplace only) 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/.	

Information about Health Savings Accounts (HSA) can be found on the next page.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Premier PPO (BCBSM Plans)

Gold

- Blue Cross® Premier PPO **Gold**
- Blue Cross® Premier PPO **Gold Extra**

Silver

- Blue Cross® Premier PPO **Silver**
- Blue Cross® Premier PPO **Silver Extra**
- Blue Cross® Premier PPO **Silver Saver HSA**
- Blue Cross® Premier PPO **Silver Secure**
(available off-marketplace only)
- Blue Cross® Premier PPO **Silver Plus**
(available off-marketplace only)
- Blue Cross® Premier PPO **Silver HSA**
(available off-marketplace only)

Bronze

- Blue Cross® Premier PPO **Bronze Extra**
- Blue Cross® Premier PPO **Bronze Saver HSA**
- Blue Cross® Premier PPO **Bronze Secure**
- Blue Cross® Premier PPO **Bronze Plus**
(available off-marketplace only)
- Blue Cross® Premier PPO **Bronze HSA**
(available off-marketplace only)

Catastrophic

- Blue Cross® Premier PPO **Value**
(under age 30 before the plan effective date)

To learn about the Premier PPO network and to see if your doctor is in network, visit bcbsm.com/marketplace/ppo/.

HealthEquity® HSA Option

The following plans can be paired with a Health Savings Account (HSA), powered by HealthEquity®:

- Blue Cross® Premier PPO Silver Saver HSA
- Blue Cross® Premier PPO Silver HSA
(available off-marketplace only)
- Blue Cross® Premier PPO Bronze Saver HSA
- Blue Cross® Premier PPO Bronze HSA
(available off-marketplace only)
- Blue Cross® Premier PPO Bronze Extra
- Blue Cross® Premier PPO Bronze Secure
- Blue Cross® Premier PPO Value
- Blue Cross® Local HMO Silver HSA
(available off-marketplace only)
- Blue Cross® Local HMO Bronze HSA
(available off-marketplace only)
- Blue Cross® Local HMO Bronze Saver HSA
(off-marketplace)
- Blue Cross® Preferred HMO Silver HSA
(available off-marketplace only)
- Blue Cross® Preferred HMO Bronze HSA
(available off-marketplace only)
- Blue Cross® Preferred HMO Bronze Saver
- Blue Cross® Preferred Bronze Extra
- Blue Cross® Preferred Bronze Secure
- Blue Cross® Preferred Value
- Blue Cross® Select HMO Silver HSA
(available off-marketplace only)
- Blue Cross® Select HMO Bronze HSA
(available off-marketplace only)
- Blue Cross® Select HMO Bronze Saver HSA
- Blue Cross® Select Bronze Extra
- Blue Cross® Select Bronze Secure
- Blue Cross® Select Value

If you already have our HSA but pick a non-HSA plan, you can still use the money in your HSA account, but can't add money to that account once your new plan starts.

There is no charge per month for our HSA. If you'd like to learn more, visit bcbsm.com/hsa. Find more details about Health Savings Accounts on Page 10 of this application.

I would like to elect the HealthEquity® HSA option

Section III: Dental, Adult Vision, and Dental with Vision plan selection

The Affordable Care Act requires that individual market medical plans include the 10 categories of Essential Health Benefits (EHBs), one of which is pediatric dental benefits. However, when sold off the Exchange, the medical plan can exclude pediatric dental coverage as long as it is reasonably assured enrollees have such pediatric dental coverage elsewhere.

This medical plan covers all 10 of the required EHBs for adults 19 years of age and older but excludes pediatric dental benefits for enrollees under 19 years of age. Therefore, you must attest to the one of the following:

All applicants are 19 years of age or older;

I have a separate qualified dental plan with another carrier that includes pediatric dental benefit coverage for applicants under 19 years of age

Insurance company: _____ Policy number: _____

I will have purchased a qualifying dental plan with pediatric dental coverage by the date my medical plan coverage starts

By signing below, I acknowledge that the above statement about the ages of all applicants or about having or purchasing a qualified dental plan that includes pediatric dental coverage is true, to the best of my knowledge and belief, and that BCBSM/BCN will rely on my statement. I certify that my attestation covers all members on the contract.

Signature _____ Date _____

To learn more about dental and vision plans, visit bcbsm.com/dental.

All dental plans include access to more than 135,000 dentists. Visit mibluedentist.com to find a dental provider.

Dental plans with vision and Blue Cross® Vision for Adults use the VSP Choice network. Visit vsp.com to find a vision provider.

For Blue Cross® Vision Glasses and Contacts for Adults in the Heritage network, visit heritagevisionplans.com to find a provider.

Dental Only Plans [†]	Dental with Adult Vision Plans ^{*†}	Adult Vision Plans [*]
Blue Dental SM PPO Plus 80/60/50	Blue Dental SM PPO Plus 80/60/50 with Vision (VSP)	Blue Cross® Vision Glasses or Contacts for Adults – monthly billing (VSP)
Blue Dental SM PPO 100/70/50 (80/60/50)	Blue Dental SM PPO 100/70/50 (80/60/50) with Vision (VSP)	Blue Cross® Vision Glasses or Contacts for Adults – annual billing (VSP)
Blue Dental SM PPO 100/50/50 (50/50/50)	Blue Dental SM PPO 100/50/50 (50/50/50) with Vision (VSP)	Blue Cross® Vision Glasses and Contacts for Adults – monthly billing (Heritage)
Blue Dental SM PPO 80/50/50 (50/50/50)	Blue Dental SM PPO 80/50/50 (50/50/50) with Vision (VSP)	Blue Cross® Vision Glasses and Contacts for Adults – annual billing (Heritage)
Blue Dental SM EPO 80/50/50 (0/0/0)	Blue Dental SM EPO 80/50/50 (0/0/0) with Vision (VSP)	
Blue Dental SM PPO Pediatric 80/50/50 (50/50/50)		

* Vision benefits are for adult members who are 19 years or older on their plan effective date. Pediatric vision benefits are included in all BCBSM/BCN medical plans.

† These Dental Only Plans and Dental with Adult Vision Plans are offered independently of any medical coverage and are not subject to medical underwriting. Tobacco use status is not considered when determining premium rates.

If you're applying for Blue Dental coverage and your comprehensive dental coverage from another carrier ended within the last 60 days, you may be eligible for a waiver of your Blue Dental waiting period. Please send in documentation that includes the date your previous coverage ended so that we may review it along with your application. Send your evidence of prior comprehensive dental coverage to:

Individual Membership and Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., Mail Code J200
Detroit, MI 48226-2998

Fax: 1-866-392-7528

Email: DirectBilledMembership@bcbsm.com

Section IV: Additional Information

If applying for a medical plan, please answer:

Is anyone listed on this application enrolled in Medicare? Yes No

If yes, who? _____

To be eligible for Medicare under age 65, you need to have one of the following:

- A disability and be receiving Social Security disability insurance for more than 24 months
- A diagnosis of end stage renal disease (ESRD)
- A diagnosis of amyotrophic lateral sclerosis (ALS) as defined by the Center for Medicare and Medicaid Services (CMS)

For more information, visit our Medicare page at bcbsm.com/medicare.

If you're eligible for Medicare, you can't apply for individual medical coverage. Please visit bcbsm.com/medicare to learn more.

Section V: Optional Information

These questions are completely optional, but your responses will help us develop programs, products and networks that meet our members' needs. Your responses won't impact your health care options or costs.

1. Please pick a primary care physician (PCP) for each family member on your plan. **If you've selected an HMO plan and don't choose a PCP, we'll pick one for you and your family members.**

If you don't know your physician's National Provider Identification (NPI) or other information, you can use our provider directory at bcbsm.com/find-a-doctor to locate the information.

	Physician's First Name	Physician's Last Name	Physician's NPI	Seen in last year?	
Applicant				Yes	No
Spouse				Yes	No
Child				Yes	No
Child				Yes	No
Child				Yes	No
Child				Yes	No

2. My yearly household income is:

Less than \$30,000	\$45,001 to \$70,000	Greater than \$90,001
\$30,001 to \$45,000	\$70,001 to \$90,000	

3. Race (check all that apply for all family members)

White	Filipino	Native Hawaiian
Black or African American	Japanese	Guamanian or Chamorro
American Indian or Alaska Native	Korean	Samoan
Asian Indian	Vietnamese	Other Pacific Islander
Chinese	Other Asian	Other

If Hispanic/Latino, ethnicity (check all that applies for all family members):

Mexican	Chicano/a	Cuban
Mexican American	Puerto Rican	Other

- 4 Preferred language (if other than English):

Arabic	Hindi	Portuguese
Chinese	Italian	Russian
French Creole	Japanese	Spanish
French	Korean	Tagalog
German	Polish	Vietnamese
Gujarati		

Section VI: Payment Options

Your security and privacy are important to us. We keep all your personal, medical and financial information confidential and safe using industry-standard certifications and information privacy practices. You can view our privacy statement at bcbsm.com/privacy.

Please tell us how you'll be paying your first monthly premium. Once you submit this application, you'll be enrolled in your plan. Don't worry; all of your payment information will be secure. Acceptable payers are the subscriber, spouse or, when applicable, the parent, blood relative, legal guardian, or other person or entity authorized under the law to pay the premium on the subscriber's behalf.

1. Who will pay the premium for this policy?

Self

Legal guardian

Family member

Other (please specify): _____

2. How do you want to pay your initial premium?

Electronic Fund Transfer (EFT); please complete section below

Bill me (coverage is contingent on payment of first premium that **must be received within 30 days** of assigned effective date)

Your health plan bill is paperless and will only be available by logging in to your member account. Simply visit bcbsm.com/register to create your member account and follow the instructions.

Once you receive your ID card in the mail, you'll need to login to your Blue Cross member account and verify your contract ID to see all billing and coverage information.

You can view your bill and submit your first payment electronically, visit bcbsm.com/paybill (your payment will be deducted two to three days after your application is approved).

Note: All billing statements are electronic. You can only view your bills online and receive monthly bill notifications in your member account. Login to your member account at bcbsm.com/member.

Electronic Fund Transfer (EFT) automatically deducts your premium payment from an account you designate.

Full name (First, Middle, Last)

Residential address

Email address

City

State

Zip code

Primary phone number

Name of financial institution

Type of account

Checking

Savings

Bank account number

ABA/Routing number (9 digits)

Automatic payment can't be processed without your signature. I authorize Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network (BCN) to deduct this one-time payment from the bank account listed above.

Signature _____ Date _____

Section VII: Consent, Terms and Conditions

BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) OR BLUE CARE NETWORK OF MICHIGAN (BCN) PLANS

ELIGIBILITY

I understand that I'm eligible for this coverage if I, my spouse and my dependents listed on this application are residents of Michigan on the effective date of the policy and that I, my spouse and my dependents listed on this application aren't eligible for and enrolled in Medicare. If anyone on this application is eligible for or enrolled in Medicare, they're eligible for a Dental, Dental with Vision, or Adult Vision Only plan. I certify that I, my spouse and my dependents listed on this application are U.S. citizens or legally present in the U.S. I understand that I must notify BCBSM or BCN immediately if my address changes.

If I am applying for coverage outside of the open enrollment period, I certify that I meet one of the qualifying events defined by the Affordable Care Act (ACA), including but not limited to, birth, adoption, change in marital status, loss of job or loss of group coverage. I am applying within the appropriate special enrollment period (SEP) as determined by my life event, and have provided appropriate documentation of my life event. I understand full details on qualifying events and special enrollment periods can be found at [healthcare.gov](https://www.healthcare.gov). I am applying for health coverage through BCBSM or BCN, based on the specific plans I selected, and understand that I'll be subject to the terms and conditions of this application, and I agree that I'll also be bound by all provisions in the applicable plan certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable. Additional information may be required of me. Coverage is contingent on payment of first premium being received within 31 days of assigned effective date.

BCBSM or BCN, as applicable, have the right to test for tobacco usage to determine applicable rates, and BCBSM or BCN, as applicable, can retroactively adjust premium rates back to the effective date based on results of tobacco (cotinine) testing. Regular tobacco use is defined as four or more times per week excluding religious or ceremonial use. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.

This coverage isn't an employer group health plan and isn't intended in any way to be an employer-sponsored health insurance plan. I certify that neither my or my spouse's employer will contribute any part of the premium, nor will I or my spouse be reimbursed for any part of the premium by the employer now, or in the future except through an Individual HRA or QSEHRA. Premium payments will be accepted from me, my spouse or, when applicable, the parent, blood relative, legal guardian, or other person or entity authorized under the law to pay the premium on the subscriber's behalf.

I may enroll my eligible spouse and eligible dependents. An eligible spouse is the legal husband or wife of the subscriber, as recognized as legal in the jurisdiction where the marriage occurred. An eligible dependent child is related to the subscriber by birth, marriage, legal adoption, legal guardianship, or foster child placement and under age 26 on the coverage effective date. I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own individual coverage. Disabled, unmarried children may remain covered after they turn 26 if certain requirements are met (not available for pediatric dental). A physician's certification of the dependent child's disability must be received 31 days after the end of the year in which they turned 26 for determination of continuing coverage under my plan.

With regard to costs of hospital and medical services delivered by or paid for by BCBSM or BCN, as applicable, I agree to assign my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under worker's compensation laws or acts whether by redemption award or voluntary payment or otherwise to BCBSM or BCN, as applicable.

I certify that the requirements of eligibility are met and that all of the information supplied on this application is true, correct, and complete to the best of my knowledge. Detailed information regarding eligibility is available for viewing in the BCBSM or BCN certificate and at [bcbsm.com](https://www.bcbsm.com). I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation or false or misleading information may result in termination or rescission of coverage.

TERMINATION OF EXISTING BCBSM OR BCN COVERAGE OR PRIOR APPLICATIONS

In applying for coverage, I am requesting termination of any other Off-Marketplace BCBSM and BCN individual policy or prior application for BCBSM or BCN Off-Marketplace coverage for which I'm a contract holder and lists the same covered members (if any) for which I have requested coverage with this application. I also request that the prior policy termination be effective as of the effective date of this coverage and prior BCBSM or BCN Off-Marketplace applications be terminated immediately. If I want to maintain my existing coverage when the coverage for which I'm applying becomes effective, I will contact BCBSM/BCN directly. On-Marketplace individual policies need to be terminated by contacting the Marketplace.

RENEWABILITY - MEDICARE

Blue Cross Blue Shield of Michigan and Blue Care Network are prohibited from renewing individual market coverage for an enrollee known to be entitled to Medicare Part A or enrolled in Medicare Part B if it would duplicate benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance.

TERMINATION OF COVERAGE

I understand that voluntary termination of my policy, including non-payment of premium, does not qualify as a life event to enroll outside of the annual open enrollment period for myself or my dependents on the policy.

I understand BCBSM or BCN may terminate my coverage, if, including but not limited to, we no longer qualify for coverage under the certificate, we can't provide proof of residency in Michigan, or for misuse of coverage.

HEALTH SAVINGS ACCOUNT OFFERED THROUGH HEALTHEQUITY®

Customers enrolled in HSA eligible plans can pair their plan with a health savings account (HSA) offered through HealthEquity. HealthEquity is an independent company partnering with Blue Cross Blue Shield of Michigan and Blue Care Network to provide health care spending account administration services. An independent and FDIC-insured bank holds the health savings account dollars.

HSA accounts will have no charge per month for administrative fees per funded account. If you've already established an HSA and switch to a non-HSA Qualified Health Plan with BCBSM, BCN, or another insurer, you will continue to own the funds in your HSA and may continue to spend from your HSA but you will no longer be able to contribute to and manage your HSA through BCBSM's/BCN's member portal at **bcbsm.com**. BCBSM/BCN will notify HealthEquity of your ineligibility and you'll receive information within one month of the date of ineligibility on how to continue managing your health savings account.

BCBSM or BCN customers who have an HSA with HealthEquity through their current or new HSA Qualified Health Plan can manage their HSA through the BCBSM/BCN member portal. If you want to discontinue management of your HSA with HealthEquity through the BCBSM/BCN member portal, you must contact BCBSM/BCN customer service directly to decouple management of your HSA from your BCBSM/BCN plan.

CATASTROPHIC (VALUE) PLANS

Catastrophic plans including Blue Cross® Premier PPO Value, Blue Cross® Preferred HMO Value and Blue Cross® Select HMO Value are available to individuals under age 30 or those who've received a certification of exemption due to affordability or hardship from the Health Insurance Marketplace. All members on the plan, including your spouse and dependents, must be under age 30 before the plan effective date, to be eligible to enroll in a value plan. If you meet this eligibility requirement, you can stay in a catastrophic plan for the duration of the calendar year in which you turn age 30.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that information collected about me as provided by this authorization will be used for the purposes noted below as well as to determine my eligibility for health coverage. BCBSM or BCN may collect personal and protected health information (PHI) about me to process my application for coverage. BCBSM or BCN will use and disclose this information only in accordance with their Notice of Privacy Practices, which is available on **bcbsm.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on BCBSM's and its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN. My authorization includes disclosure of information on the diagnosis and treatment of human immunodeficiency virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This PHI is to be disclosed so that BCBSM or BCN may: (1) perform case, care and disease management, (2) validate rating factors allowable under the Patient Protection and Affordable Care Act (PPACA), (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (4) for other legally permissible purposes, including but not limited to, health care operations.

If BCBSM rediscloses this information, the recipient must obtain an additional authorization from me before it may redisclose the information and, if I provide this authorization, information may be redisclosed by the recipient and is no longer protected. I understand and acknowledge that if I'm applying for coverage from BCN that this restriction on redisclosure doesn't apply, but if BCN does redisclose my information, it may no longer be protected.

I understand that my enrollment with BCBSM or BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I don't provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM or BCN and its subsidiaries and from any of the parties listed above to BCBSM or BCN. A copy or other reproduction of this authorization shall be valid as the original. My authorization expires upon the later of (i) rescission or rejection of coverage by BCBSM or BCN; or (ii) I cause my coverage to terminate or it otherwise expires. I understand that I'm entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **bcbsm.com** or by contacting my Blue Cross agent. I understand that revocation won't affect actions taken before BCBSM or BCN or any of the parties identified above receive my request.

REFUND POLICY

I understand that requests to terminate coverage will be accepted by me, the card holder, and if I terminate coverage, BCBSM or BCN will refund the unused portion of the monthly premium that was paid, if applicable. BCBSM or BCN will mail me a check within 30 days from the date of my termination. Details about terminating coverage can be found in the certificate or by contacting the number on the back of my BCBSM or BCN card.

I may terminate my coverage by notifying BCBSM or BCN within 10 days of the effective date of my coverage. I will receive a full refund of my premium. If I terminate my coverage after 10 days, I will receive a prorated refund on the unused portion of my premium.

Refunds for Blue Cross® Vision for Adults will only be granted to those members that have elected to pay annually and have no benefit utilization **by anyone on the contract** for the given year for which a premium has been paid in advance. These refunds will be processed by request as of the first of the following month.

Section VIII: Sign and Date

Please review your application for completeness and accuracy, and sign and date below.

SUMMARY OF BENEFITS AND COVERAGE

I understand that a Summary of Benefits and Coverage (SBC) related to the coverage for which I'm applying is available on the web at bcbsm.com/sbc. I understand the SBC isn't a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the SBC and my applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the SBC electronically via the website. I understand a paper copy is also available, free of charge, by calling BCBSM at 1-888-288-2738 or BCN at 1-888-227-2345, as applicable.

Health plan communications and digital opt-in

By submitting this application, you consent to electronically receive communications about your health plan from Blue Cross Blue Shield of Michigan and Blue Care Network via email and SMS text message. You understand that you can request paper copies by calling the number on the back of your member ID card after enrollment.

To manage communication preferences and/or unsubscribe, please sign in to your Member Account at bcbsm.com/login/ or via the BCBSM Mobile App. For any additional support, call Customer Service at the number on the back of your Member ID card.

bcbsm.com/agentcompensation: This URL will allow members to see information related to agent commissions.

To include a non-opioid directive in your medical records, please fill out the form available at bcbsm.com/opioids/index/. Once completed, send or email a copy to your primary care physician.

Approval of this application and coverage effective date will be determined by BCBSM or BCN as applicable.

Signature of primary applicant (if child only policy, legal guardian must sign)		Date
Mail your completed application to: Individual Membership and Billing Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd, Mail Code J200 Detroit, MI 48226 Or fax to: 866-392-7528		
Area below for Blue Cross agent use only		
Agent first name	Agent last name	5-digit agent code
GA name	GA 2-digit code	National producer number
Name of person entering enrollment information online First nameLast name		
Date producing agent accepted paper enrollment form from individual		Date _____(mm/dd/yyyy)
Date general agent or association received paper enrollment from agent		Date _____(mm/dd/yyyy)
Agent signature		Date signed

HealthEquity® is an independent company that contracts with Blue Cross Blue Shield of Michigan to provide spending account services.

