



**Blue Cross
Blue Shield
Blue Care Network**
of Michigan

CA Choice Enrollment BCBSM BCN

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

BCBSM Group	BCN Group ID	Subscriber signature	Date
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Subscriber information

Subscriber Social Security number (Required)	Subscriber last name	Subscriber first name	MI	Marital status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Subscriber birth date
Home street address		City	State	ZIP Code	E-mail	
County	Country – if other than USA	Primary phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Relationship (See instructions on back)	

List all persons to be covered:

	Last name	First name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Social Security number
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F		
Dep. 1				<input type="checkbox"/> M <input type="checkbox"/> F		
Dep. 2				<input type="checkbox"/> M <input type="checkbox"/> F		
Dep. 3				<input type="checkbox"/> M <input type="checkbox"/> F		
Dep. 4				<input type="checkbox"/> M <input type="checkbox"/> F		

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

Medicare primary BCBSM or BCN primary

Medicare A effective date: _____ Medicare B effective date: _____ Medicare D effective date: _____

Medicare ID _____

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- M.C. 610I
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- M.C. C300
Blue Care Network
P.O. Box 5043
Southfield, MI 48086
Fax: 1-877-218-1466

Email: CAChoiceEnrollment@bcbsm.com