Change of Status

☐ BCBSM ☐ BCN Member (see instructions on Page 7)

BCBSM group	Division	BCN group number	Subgroup number	Class number	Employer representative signature	Date
—						

Subscriber information *Required field

Subscriber Social Security number (*Required)	Subscriber last name*	Subscriber first name*	M.I.*	Marital status* ☐S ☐M	Gender ☐M ☐F

New home street address*	City*	State*	ZIP code*	E-mail*

County*	Country – if other than USA*	New primary phone* ☐ Home ☐ Work ☐ Cell	New secondary phone* ☐ Home ☐ Work ☐ Cell	* Indicate changes only

List all persons to be added or deleted:

	Last name	First name	M.I.	Gender	Date of birth	Social Security number (Required)	Relationship code (See instructions for codes)
Spouse ☐Add ☐Delete				☐M ☐F			
Dep. 1 ☐Add ☐Delete				☐M ☐F			
Dep. 2 ☐Add ☐Delete				☐M ☐F			
Dep. 3 ☐Add ☐Delete				☐M ☐F			
Dep. 4 ☐Add ☐Delete				☐M ☐F			

If the permanent address of the spouse or dependent is different from the address above, please complete the following information:	Spouse or Dependent (full name)	Home street address	City	State	ZIP code

Coordination of benefits information

Do you, your spouse or dependents maintain other health coverage? ☐Yes ☐No If yes, complete below: ☐Check here if this applies to all members on the contract.

Person covered (full name)	Group name	Policy number	Carrier	Address

I have read and understand the conditions of this form. Subscriber signature: Date:

Flexible spending account arrangements

☐FSAMED Effective date: ________ Goal amount: ________ ☐FSAPARK Effective date: ________ Goal amount: ________

☐FSADEPCA Effective date: ________ Goal amount: ________ ☐FSATRANS Effective date: ________ Goal amount: ________

☐ Add ☐ Change ☐Cancel

Employer/Group use only

Group name	Employe I.D. badge or department #	Benefit code	Plan code

Check reason for change below:
☐ Marriage ☐ FC/DCCR ☐ Loss of coverage
☐ Dependents ☐ Name change
Date of event: ________ Effective date: ________

Check type of cancellation and reason below. Type: ☐ Contract ☐ Spouse ☐ Dependents
Reason: ☐ COBRA ☐ Death ☐ Left employment
☐ Divorce ☐ Dependent over age ☐ Other
☐ Retired ☐ Other insurance
Last date of coverage: ________

Loss of prior coverage? ☐Yes ☐No If Yes, complete below:

Carrier's name (includes BCBSM or BCN)	Contract holder name	Policy #	Termination date

Are any listed members enrolled in Medicare? ☐ No ☐ Yes If Yes, check category ☐ Over 65 and working ☐ Retired ☐ Disabled ☐ ESRD

☐ Medicare primary per MSP laws
☐ BCBSM or BCN primary per MSP laws
Medicare A effective date: ________ Medicare B effective date: ________ Medicare D effective date: ________ HIC #: ________

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