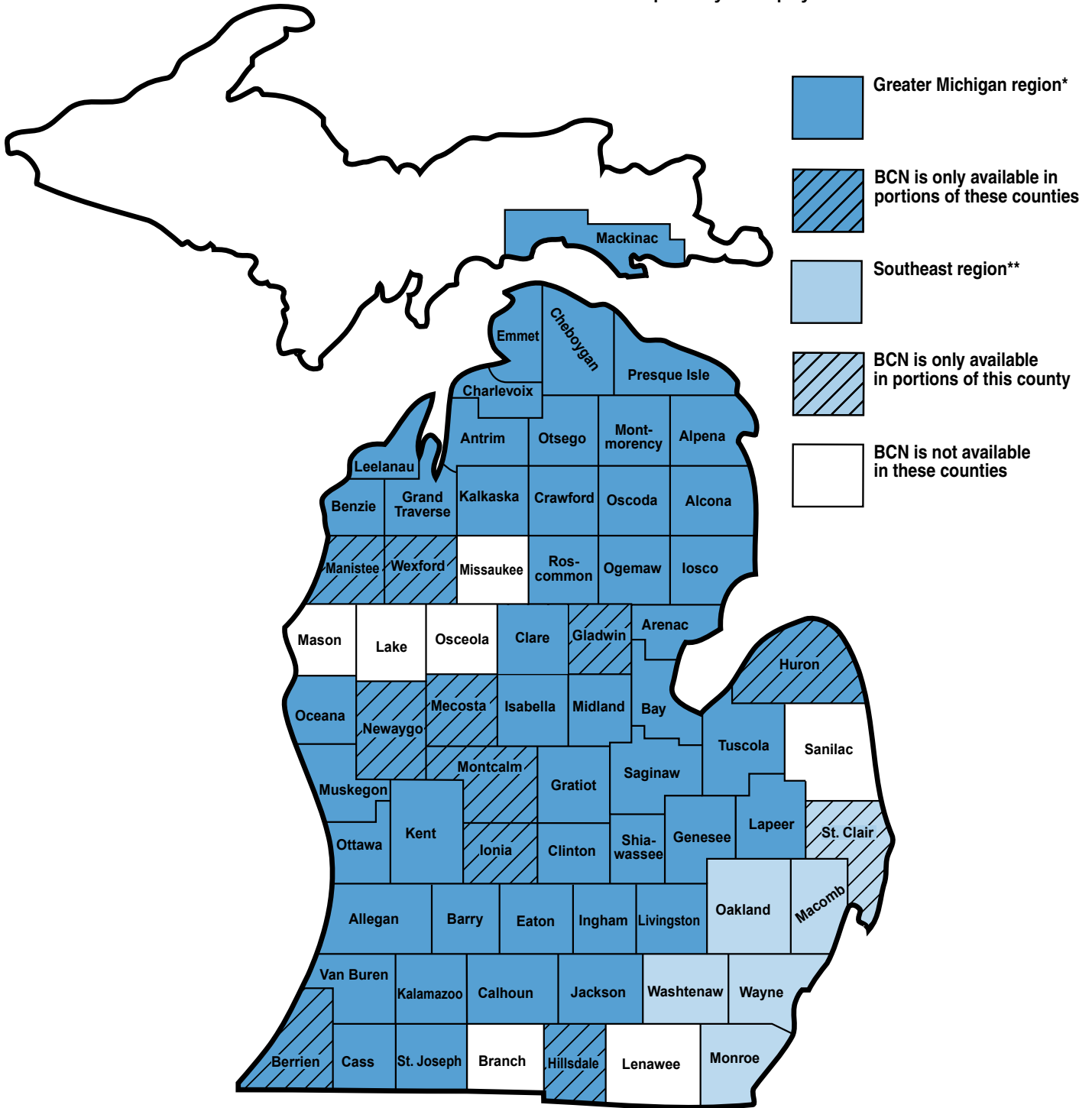




Blue Care of Michigan, Inc.

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

Personal Plus members may select any primary care physician in Blue Care Network.



Personal Plus Enrollment Form



Personal Plus Enrollment Form Instructions

For your application to be processed, you must complete all sections.

Please PRINT or TYPE all information. To duplicate on yellow copy (yours to keep), print firmly.

- Section 1: If it applies, include apartment number or P.O. box in address. List the first and last name and middle initial of all persons that you wish to cover including yourself. List each person's sex, birth date and Social Security number. In the Relationship code box, list the code for each person's relationship to you (such as N-Natural child, S-Stepchild). In divorce/paternity cases, you must include legal documentation (such as divorce decree or custodial decree). List a BCN participating primary care physician* for each person. List the physician's name, code (if known*) and location (street and city). Check "yes" or "no" whether each person has been seen by the physician within last 12 months or is a current patient. If it applies, list the alternate address of your spouse or dependents.
- *Select a physician, look up a provider code or "NPI," check a location and more at **MiBCN.com/find**.
- Section 2: If any person listed in Section 1 has other medical insurance coverage either through an employer or on an individual basis, list his or her name, employer group's name, policy number and the insurance carrier or HMO's name and location.
- Section 3: Sign and date the form.

If your application is approved, we will mail you an invoice for payment.

Questions? Call Customer Service

1-800-662-6667

1-800-257-9980 (TTY)

8 a.m. to 5:30 p.m. Monday through Friday

Mail the completed white and blue enrollment form (keep the yellow copy), the completed Health Questionnaire and, if required, other documents in the enclosed postage-paid envelope, or mail all in your own envelope to:

Enrollment Applications – Audit Specialist – C411

Blue Care Network of Michigan

P.O. Box 5043

Southfield, MI 48086-5043

For more information, visit **MiBCN.com**.



Please Print Clearly

PERSONAL PLUS ENROLLMENT FORM

Subscriber Social Security number		Subscriber last name <input type="checkbox"/> check if new		Subscriber first name		M.I.	Area code/evening phone		Area code/day phone						
Street address				City		State	ZIP code	County		Current marital status <input type="checkbox"/> Single <input type="checkbox"/> Married					
List all persons to be enrolled / terminated:															
SUBSCRIBER SECTION 1	CIRCLE ONE Add Delete	LAST NAME	FIRST NAME	MAY DELETE	SUM X	DATE OF BIRTH mo. day year	SOCIAL SECURITY NO.	* RE LEAS E	PRIMARY CARE PHYSICIAN NAME - BCN ONLY				Seen in last 12 months or current patient		
									LAST NAME	FIRST INITIAL	PHYSICIAN #	PHYSICIAN LOCATOIN	YES	NO	
Subscriber															
Spouse															
Dep-1															
Dep-2															
Dep-3															
*Relationship code						Previous Blue Care Network affiliation			PCP change reasons						
N – Child (by birth or adoption)		P – Principle support*		SD – Sponsored dependent*		I have previously been enrolled in: (Check applicable box)									
S – Stepchild		A – Child adoption in progress**		C – Court ordered coverage (QMSCO)**		<input type="checkbox"/> BCBSM <input type="checkbox"/> BCN									
F – Family Continuation 19+ * = Attach legal documentation		L – Legal guardianship** ** = Attach court order		D – Disabled child (PA218)*** *** = Attach physician statement		Enter contract # _____									
If the permanent address of spouse or dependent is different from address in section one, please complete information below:															
Spouse/dependent (Full name)				Street address				City		State	ZIP code				
Do you, your spouse or dependent(s) maintain other health coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, complete below:															
Person covered (full name)			Group			Policy number			Carrier		Location				
Person covered (full name)			Group			Policy number			Carrier		Location				
Are you, your spouse or any dependents listed in section 2 enrolled in Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, attach a copy of Medicare card. <input type="checkbox"/> Actively working <input type="checkbox"/> Retired <input type="checkbox"/> Under 65 <input type="checkbox"/> ESRD (End Stage Renal Disease)															
I have read and understand the conditions on the reverse side of this form.															
Subscriber signature						Indicate name of employer or self-employed									
If you or a dependent are covered under another health care policy, please explain why you are applying for this coverage. (Use space provided below.)															
Are you or any of your dependents who are applying for Personal Plus covered by:															
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of person covered						Policy number							
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of person covered						Policy number							
Children's Special Health Care Services <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of person covered						Policy number							
I have read and agreed to the terms on the back of this form. I understand that approval of this application and coverage effective date will be determined by Blue Care Network and Blue Care of Michigan, Inc. and is subject to payment at the applicable rates. I authorize BCN to obtain from providers of service and hospitals the medical records relating to me and my family members necessary to the administration of my contract with Blue Care of Michigan, Inc. I understand that I may cancel my Personal Plus in writing within 72 hours of its effective date, and that my previous payment will be refunded promptly. I understand that I must pay a reasonable fee for any services I or my dependents receive from BCN during the 72 hours.															
Type of enrollment (check one) <input type="checkbox"/> Single <input type="checkbox"/> Two-person <input type="checkbox"/> Family				Enrollee signature						Date					
BCN USE ONLY		Effective date		Group I.D./Subgroup I.D./Class I.D.						Date					

CONDITIONS FOR COVERAGE:

I understand that I am applying for myself and eligible members of my family for health coverage in the Personal Plus Program offered by Blue Care of Michigan, Inc. administered by Blue Care Network of Michigan (BCN). The coverages shall not exceed those benefits and services contained on the Personal Plus certificate and riders.

I may enroll my legal spouse and eligible children who reside in the Blue Care of Michigan, Inc. service area. Eligible children are defined as my or my spouses's children by birth, legal adoption, foster parenthood, or legal guardianship. Eligible children must be under 18 years of age, financially dependent upon me, or are a part of my household. I may not enroll myself, my spouse, or any dependents who are eligible for, beneficiaries of, recipients of Medicare or Medicaid or who are eligible for any employer sponsored health benefit plan.

I AND MY ENROLLED FAMILY MEMBERS AGREE THAT ALL OUR MEDICAL SERVICES MUST BE PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED BY OUR DESIGNATED BCN PRIMARY CARE PHYSICIAN(S) EXCEPT IN THE CASE OF AN IMMEDIATE AND UNFORESEEN MEDICAL EMERGENCY AND THE TIME NEEDED TO CONTACT OUR PRIMARY CARE PHYSICIAN MAY MEAN PERMANENT DAMAGE TO OUR HEALTH. UNAUTHORIZED SERVICES THAT ARE NOT AN IMMEDIATE AND UNFORESEEN EMERGENCY, AS DESCRIBED ABOVE, RECEIVED FROM PHYSICIANS NOT PARTICIPATING WITH BCN WILL NOT BE COVERED.

I authorize Blue Care of Michigan, Inc., BCN and my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with and for other purposes necessary for BCN and Blue Care of Michigan, Inc. to fulfill its contractual and statutory obligations.

I authorize any holder of medical or other information about me or my enrolled family members to release to the Centers for Medicare and Medicaid Services, any insurance company, or any HMO and their agents any information needed to determine benefits coverage. I request that payment of authorized Medicare, Medicaid, insurance company or HMO benefits be made payable to Blue Care of Michigan, Inc. on my behalf for any services furnished to me by Blue Care of Michigan, Inc.

I agree to assign to BCN and Blue Care of Michigan, Inc. my entire right to recovery of the cost of hospital and medical services delivered by or paid for by BCN or Blue Care of Michigan, Inc. 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.

I understand that the benefits I will be eligible for are described in the Personal Plus Certificate and that the Blue Care of Michigan, Inc. marketing materials are only a summary.

I understand that I may protest a proposed amendment in this contract or rate charged within 30 days of receipt of notice, and that my continued payment while an appeal is in progress shall not be deemed to constitute acceptance of the proposed amendment or rate change.

I understand that I may cancel this contract within 72 hours of signing this form, and that my previous payment will be refunded promptly.

I understand that I must pay a reasonable fee for any services I or my dependents receive from Blue Care of Michigan, Inc. during the 72 hours.

I UNDERSTAND THAT I AND MY ENROLLED FAMILY MEMBERS WILL NOT BE COVERED FOR SIX MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE FOR ANY AND ALL CONDITIONS THAT MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN 6 MONTHS BEFORE MY ENROLLMENT.

THE TERM "CONDITIONS" INCLUDES, BUT IS NOT LIMITED TO, MATERNITY CARE, OBSTETRICAL CARE, OR TERMINATION OF PREGNANCY. I UNDERSTAND THAT MY ENROLLMENT DATE BEGINS ON THE EFFECTIVE DATE OF COVERAGE AS DETERMINED BY BLUE CARE NETWORK.

I UNDERSTAND THAT ACCEPTANCE OF MY APPLICATION WILL BE SUBJECT TO MEDICAL UNDERWRITING.

If transferring from BCBSM coverage, or Blue Care Network coverage, I further understand that the exclusions for the pre-existing conditions listed above will be waived, only to the extent that I and any dependents included for coverage have satisfied the waiting period, provided there is no lapse in coverage when transferring to Personal Plus.

I certify the above information is true, correct, and complete to the best of my knowledge and belief. I understand the information will be used in reviewing my application and administering coverage and my failure to provide complete and accurate answers or my submission of false or misleading information may result in voiding of coverage for myself and my family, denial of claims or cancellation.