



Individual Billed Member Change of Status Request

| | | |
|-----------------|--------------|----------------------------|
| SUBSCRIBER NAME | GROUP NUMBER | CONTRACT NUMBER (Required) |
| | | |

Please type to ensure accurate processing of your request.

MEMBER CHANGES

Add¹ the following person(s) to my contract. Note: A copy of a driver's license is required to add anyone age 19 years or older.

Reason: Marriage Birth Other _____

Remove the following person(s) from my contract:

Reason: Death Divorce Enrolled in Medicare Blue (Contract ID# _____) Effective Date: _____ Other: _____

| Last Name | First Name | M.I. | Sex | Date of Birth MM/DD/YYYY | Social Security Number | Date of Event | *Rel. Code |
|-----------|------------|------|-----|-----------------------------|---------------------------|---------------|---------------|
| Spouse | | | | | | | |
| Dependent | | | | | | | |
| Dependent | | | | | | | |

*Relationship Codes:

- | | | |
|--------------------------------------|---|---|
| N – Biological/Adopted Child | P – Principal Support (Attach Court Document) | C – Court Order Coverage (QMSCO) (Attach Court Order) |
| S – Stepchild | A – Child Adoption in Progress (Attach Court Document) | D – Disabled Child (PA275) (Attach Physician Statement) |
| F – Family Continuation 19-25 | L – Legal Guardianship (Attach Court Document) | |

COVERAGE CHANGES

Change my health care plan to⁸:

Traditional plans: **Option A** **Option C²**

PPO plans:

- Individual Care Blue Plus²**
 optional Flexible Blue Dental Plus
 Flexible Blue II- 1500²
 optional Flexible Blue Dental Plus
 optional maternity

Young Adult Blue Max³

- Flexible Blue II- 2500**
 optional Flexible Blue Dental Plus
 optional maternity
 Flexible Blue II- 5000
 optional Flexible Blue Dental Plus

Keep Fit²

- 1500
 2500
 5000
 7500
 10,000

Stand-alone Dental Plans⁴: **Personal Blue Dental** **Personal Blue Dental Plus**

Medicare Supplemental plans⁵: **Plan A** **Plan C**

To enroll in Medicare Advantage (Medicare Plus Blue or Prescription Blue Plans), you must call 1-800-485-4415

Note: If you are under 65 Non-Medicare and changing to a Medicare supplemental plan you must submit a new application.

OTHER CHANGES

Name Change: Last Name _____ First Name _____ Middle Initial _____

Address Change: _____

| | | | |
|---------|------|-------|----------|
| Address | City | State | Zip Code |
|---------|------|-------|----------|

Telephone Number Change: _____

I certify that the requirements of eligibility are met and that the information I have given on this Change of Status Request is true and correct to the best of my knowledge.

Terminate^{6,7} my contract effective next billing period or as of this date _____. If you terminate your coverage, you will not be allowed to enroll in any BCBSM individual market product for 6 months after your termination date.

Medicare Plus Blue ID# _____

Effective Date: _____

SUBSCRIBER'S SIGNATURE

DATE

Mail all change of status requests to:
Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit MI 48244-0407

Premium payments sent to this address could delay access to your benefits
 You may **Fax** to: **1-866-392-7528**

For questions, please call the customer service number located on the back of your BCBSM ID card.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

NOTES

1. If current product not listed, only newborns can be added to current coverage. Notification required within 30 days of birth.
2. Not available as Group Conversion
3. EFT and e-mail address required to enroll in Young Adult Blue Max. Call the customer service number located on the back of your BCBSM ID card to change to Young Adult Blue Max.
4. Stand-alone dental plans are available as an option to all products except Individual Care Blue Plus, Flexible Blue II-1500, Flexible Blue-2500, and Flexible Blue II- 5000
5. If new to Medicare and changing to Medicare Supplemental Plan, you must submit a new application.
6. If moving to Medicare Plus Blue plan please provide your ID number and effective date.
7. Requests to terminate coverage must be for a future date unless the member has passed away. Some Exceptions apply when termination is due to obtaining other Blue Cross Blue Shield of Michigan coverage.
8. Benefit changes are allowed after 12 months of coverage or at least 12 months since the last benefit change.