



CONFIDENTIAL

APPLICATION

for consideration to serve on the Board of Directors or on the Small Group Subscriber Director Selection Council

Are you interested in applying for membership on

Board of Directors

Small Group Subscriber Director Selection Council

(You may check both if you wish, though you could serve on only one at a time.)

Please print or type.

1. Full name: _____

Last
First
Middle
2. Current employer or other principal business affiliation:
3. Business address:
4. Business phone: _____ Fax: _____
5. Position title: _____
6. If union member, give union name, local and position:
7. If retired, give year: _____
8. Home address:
9. Home phone: _____ Fax: _____
10. Social Security Number: _____
11. BCBSM health care coverage I.D. card (**Blue Care Network members not eligible**):
 Group #: _____ Contract #: _____

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

12. Are there other health care carriers covering members of your organization?

YES NO

If YES, is BCBSM the larger carrier?

YES NO

13. Organizations of current affiliation and position title:

14. Brief statement of qualifications and experience in the health care benefits, corporate management or other fields which would qualify you:

(If more space is needed, attach additional page.)

15. Check highest level of education completed:

High School

Associate Degree

Bachelor's Degree

Master's Degree

Doctoral Degree

Other_____

16. Current license/certification (examples: CPA, MD, CSW)

Type_____

17. Please attach resume, biographical information or other materials relevant to your application.

Other interests: For purposes of determining statutory compliance, bylaw qualifications and federal contract compliance, please answer the following questions with a “yes” or “no” response only. If an occurrence happens at all (i.e., sometimes, once in a while, occasionally, etc.), the response is “yes.” Explanation of “yes” answers should be provided on Page 4. You are precluded from serving as a subscriber member of the BCBSM board if you are a provider or have a provider affiliation. Provider representatives on the BCBSM board are selected by various medical entities. *(See reverse side for provider definitions.)*

EXPLAIN ANY "YES" ANSWER IN SPACE PROVIDED ON REVERSE SIDE.

1. Are you: a provider; employed by a provider; a director, officer or trustee of a provider; a spouse, parent or child of a provider who resides in the same household; or do you have a 5% or greater ownership interest in a provider?

Yes No

(See Page 4 for provider definitions.)

2. Do you receive more than 25% of your annual income through the provision of goods or services to providers, or are you an employee, officer, trustee or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to providers?

Yes No

(See Page 4 for provider definitions.)

3. Are you an employee, agent, officer or director of a disability insurance company?

Yes No

4. Do you, or does any organization with which you are affiliated or in which you have a 5% or greater ownership interest, supply goods or services to BCBSM?

Yes No

5. Do you personally negotiate, or influence negotiations, with BCBSM staff regarding the prices or terms of health care programs for your group?

Yes No

6. Have you, directly or indirectly, received any valuable gift or favor (other than common business courtesies) from any organization doing business with BCBSM?

Yes No

7. Do you have an affiliation with any organization which is in competition with BCBSM or any of its subsidiaries or an affiliation with any organization the interests of which might be considered in conflict with the interests of BCBSM?

Yes No

8. Please go to Page 5.

Certification and Authorization: I hereby certify the information in this application is complete and accurate to the best of my knowledge and I acknowledge my obligation to promptly inform BCBSM of any material changes. I further authorize BCBSM to verify the above information and my status as a current subscriber or member enrolled to receive health care benefits administered by BCBSM or one of its subsidiaries or affiliates.

(Date)

(Signature)

Provider Definitions

Facility Providers

Ambulance and Emergency Medical Services	Hospitals
Ambulatory Health Care Facilities	Intermediate Care Facilities
Clinical and Other Laboratories	Kidney Disease Treatment Centers
County Medical Care Facilities	Mental and Psychiatric Hospitals
Freestanding Hemodialysis Units	Nursing Homes
Freestanding Outpatient Surgical Facilities	Outpatient Physical Therapy Agencies
Health Maintenance Organizations	Outpatient Psychiatric Care Facilities
Home Health Agencies	Pharmacies
Home Infusion Therapy Providers	Skilled Nursing Facilities
Homes for the Aged	Substance Abuse Treatment Programs
Hospices	Tertiary Health Services Facilities
Hospital Long Term Care Units	

Professional Providers

Acupuncturist	Medical Doctors	Physician's Assistants
Athletic Trainer	Nurse Anesthetists	Podiatrists
Chiropractors	Nurse Midwives	Professional Counselors
Dental Assistants	Nurse Practitioners	Psychological Assistants
Dental Hygienists	Occupational Therapists	Psychologists
Dentists	Optometrists	Registered Nurses
Dietitians or Nutritionists	Osteopaths	Social Workers
Licensed Practical Nurses	Pharmacists	Speech and Language Pathologists
Marriage and Family Therapists	Physical Therapists	Trained Attendants

Other Providers

Audiometrists	Prosthetic-Orthotic Appliance Dealers
Audiologists	Psychiatric Units
Durable Medical Equipment	Rehabilitation Centers
Hearing Aid Dealers	Respiratory Care Professionals
Hearing Therapists	Sanitarians
Nursing Home Administrators	Veterinarians
Opticians	

Explanations

Please show question number for which explanation is given. Use extra sheet, if necessary.

PLEASE MAIL COMPLETED FORM TO:

Corporate Secretary
Blue Cross Blue Shield of Michigan
600 East Lafayette Blvd. #2015
Detroit, Michigan 48226-2998

