Blue Cross Blue Shield of Michigan

AGENT
Change of Status Request Form For Individual Billed Member

On-line directions

SUBSCRIBER NAME	CONTRACT NUMBER (Required)

MEMBER CHANGES

☐ **Add** 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* to ☐ Birth* of *(must be notified within 30 days of event*)* ☐ Other:_____

☐ **Remove** the following person(s) from my contract:

Reason: ☐ Death ☐ Divorce ☐ Enrolled in Medicare Plus Blue (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
S – Stepchild
P – Principal Support (Attach Court Document)
A – Child Adoption in Progress (Attach Court Document)
L – Legal Guardianship (Attach Court Document)
C – Court Order Coverage (QMSCO) (Attach Court Order)
D – Disabled Child (PA275) (Attach Physician Statement)

COVERAGE CHANGES

☐ **Change: (Changes are allowed after 12 months or at least 12 months since the last change.)**
Note: Group Conversion is not available for Individual Care Blue Plus, Flex Blue II 1500 or Keep Fit

Young Adult Blue Max Call the Agent Hotline at 1-800-788-7334 to change to Young Adult Blue Max, EFT and e-mail address is required.

PPO plans:

☐ **Individual Care Blue Plus**
- ☐ optional Flexible Blue Dental Plus

☐ **Flexible Blue II- 1500**
- ☐ optional maternity
- ☐ optional Flexible Blue Dental Plus

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

☐ **Flexible Blue II- 5000**
- ☐ optional Flexible Blue Dental Plus

☐ **Keep Fit**
- ☐ 1500
- ☐ 2500
- ☐ 5000
- ☐ 7500
- ☐ 10,000

Dental Plans: ☐ **Personal Blue Dental** ☐ **Personal Blue Dental Plus**

Personal Blue Dental and Personal Blue Dental Plus are only available for Young Adult Blue Max, Keep Fit and Closed Products

EFFECTIVE DATE CHANGES

Choose from the following date: 1st or 15th

☐ **Change** my future effective date to: _____(MM/DD/CCYY)
(non-group only) (only within 30 days of effective date)

OTHER CHANGES

☐ **Name Change:**
☐ **Address Change:**

Last Name	First Name	Middle Initial

Address	City	State	Zip Code

☐ **Telephone Number Change:** _____

☐ **Terminate Contact** effective next cycle date following the receipt of this request or as of this date _____.
Note: you will not be allowed to enroll in any BCBSM individual market product for 6 months after your termination date.

_____ _____
SUBSCRIBER'S SIGNATURE (Required for Contract Termination ONLY) DATE

Please contact the Agent Hotline at 1-800-788-7334 for questions.

Agent code	MA/GA code	Assn./Chamber code	Managing Agent/General Agent/Agent Signature

E-mail all Change of Status request to: IBUAgentMembershipRequests@bcbsm.com **OR Fax to: 866-392-7528.**

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