



Application for Individual Care Blue SM

PLEASE PRINT CLEARLY

To be eligible for this coverage, you must reside in Michigan at least six months a year and cannot be enrolled in Medicare.

Your Last Name	First Name	Initial	Requested Coverage Start Date (N/A if you answered "Yes" to question 2.) MMDDYYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - Must be Future Date

Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Telephone Number with Area Code	Date of Birth MM/DD/YYYY	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

If you wish to apply for coverage for a spouse and/or unmarried children who are under age 19 or who will turn 19 this year, please list them below. Provide last name if different from yours. (Please use an additional sheet of paper for more than three children.)

Last name (Spouse)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

If you wish to apply for coverage for an unmarried child who is age 20-25 this year, please complete below. Provide last name if different from yours. (Please use an additional sheet of paper for more than one child.)

Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

- Do you live in Michigan six or more months each year: Yes No
- Are you currently active under a Blue Cross Blue Shield of Michigan (BCBSM) employer-sponsored group health plan or have you left a BCBSM employer-sponsored group health plan within the last 60 days? Yes No
If yes, please provide your:
Contract Number Group Number Policy End Date MM/DD/YYYY

- Are any individuals listed above:
 - Enrolled in Medicare? Yes No
 - Eligible for or enrolled in a group-sponsored health plan? Yes No If yes, when will your current policy terminate?
 - Enrolled in an individual (non group) health Plan? Yes No If yes, when will your current policy terminate?
- Will your current employer contribute toward or reimburse you for any portion of your individual coverage? Yes No

I am applying for BCBSM coverage subject to the terms and conditions in the material that accompanied this application and I agree that I and my covered dependents will be bound by all provisions in the BCBSM certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills. I certify that the requirements of eligibility are met and that the information I have given on this application is true and correct to the best of my knowledge. I authorize BCBSM to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCBSM has the right to use and disclose these records and other confidential member information for valid business purpose.

Shaded Areas for BCBSM Use Only			Signature of Applicant		Date
Agent Code	MA Code	Assoc./Chamber Code	Agent's Signature	Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Group Number	Service Code	Eff.Date: MMDDYYYY	U/W:	Preex Date	DEID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Preexisting Condition Waiting Period

If you have a preexisting condition, there may be an initial 180-day waiting period from the start date of your coverage for which related claims may not be reimbursable. You may be eligible to waive the preexisting condition waiting period associated with BCBSM non-group coverage (including any limitation on pregnancy benefits) if you meet all of the following criteria:

- Prior to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, freestanding prescription drug coverage, or other health plans. Freestanding dental and vision coverage cannot be counted as prior health care coverage.
- Your most recent health coverage must have been through a group health plan. (Please note that even though health coverage might be provided through an association or other organizations, it is considered to be “individual” health insurance if it is not provided through an employer-sponsored group health plan. Also, a business owner and spouse are usually not considered employees of a business if no other employee partakes in the health plan. If this is the case, the health plan cannot be defined as a “group” health plan but is instead an individual plan. If, however, the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan. Proof may be required of employee status.)
- You have elected and exhausted any COBRA coverage for which you were eligible.
- You are no longer eligible for group coverage and you are not eligible for Medicare or Medicaid.
- Your prior coverage was not terminated due to premium nonpayment or fraud.

When your application is processed you will receive a welcome letter that further explains waiving the preexisting condition waiting period.

Check List for Submitting Your Application

- Review your application for completeness and accuracy
- Sign and date your application
- Submit your application (page 1 of 3) and Automatic Payment Plan enrollment form (page 3 of 3) as follows:
 - If you are enrolling through an independent agent, submit your application directly to your agent so that they can process the application for you
 - If you are enrolling directly with BCBSM, please mail your completed application to:

**Blue Cross Blue Shield of Michigan - MC B576
600 E. Lafayette Blvd.
Detroit, MI 48226-9942**

After your application is reviewed and approved, you will receive a bill. A start date for your coverage will be assigned as close as possible to the date you requested on the application (page 1 of 3) or as close as possible to the “Policy End Date” indicated in question 2. (on page 1 of 3). Your coverage will become effective upon receipt of payment.

Questions: 1-800-869-BLUE (2583)



Automatic Payment Plan for Individual and Direct Billed Customers

BCBSM Automatic Payment plan offers the convenience of paying your health care bill on time, every time. No need to write checks, mail payments or worry about late payments resulting in rejected services. To participate, simply fill out and mail in this enrollment form. Please include a blank, voided check or a deposit slip from your designated account for verification. Please allow 3-4 weeks for processing your application. Continue to mail your payment as usual until you see "Automatic Payment" on your bill.

Enrollment is easy. Just complete this enrollment form and mail it along with your Individual Care Blue application.

Please complete the requested information below: (Please print or type)

Last NameFirst NameMiddle Initial

Address

CityStateZip Code

()

Daytime Phone Number

Please include a blank, voided check or deposit slip from your designated account

Name of Financial Institution

Please check one: Checking Account Savings Account

Bank Account NumberABA/Routing Number (9 digits)

This form cannot be processed without your signature

I authorize Blue Cross Blue Shield of Michigan to deduct my payments from the checking or savings account listed above. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify BCBSM. I also understand that all information provided will remain confidential.

SignatureDate

BCBSM Use Only

DEID					