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# HMO

## HMO Health Insurance Enrollment and Change Form

Employee/Subscriber Information											
Social Security Number		BCN Group and Division # 00124677 -		Date of Hire		Employee Department		Employee Group		Employee ID	
Effective Date	Last Name			First Name			MI	Date of Birth		Home Phone	
Home Address			City		State	Zip Code		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	
<b>Plan: Healthy Blue Living HMO</b>				<b>Desired Action – Enroll or Cancel</b>							
<input type="checkbox"/> Waive upon hire <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Single (employee only) <input type="checkbox"/> Double (employee & 1 family member) <input type="checkbox"/> Family (employee & 2 or more family members)				Reason for Enrollment				Reason for Cancellation			
				<input type="checkbox"/> New Hire/Rehire <input type="checkbox"/> Birth/Adoption/Foster Care <input type="checkbox"/> DEI Event <input type="checkbox"/> Marriage <input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Return to Work (LOA) <input type="checkbox"/> Other Reason: <input type="checkbox"/> Cobra Enrollment <input type="checkbox"/> Transfer New Suffix:		<input type="checkbox"/> No Longer Employed <input type="checkbox"/> Deceased <input type="checkbox"/> Divorce <input type="checkbox"/> LOA <input type="checkbox"/> Other Reason:		<input type="checkbox"/> Loss of Dep Status <input type="checkbox"/> Other Insurance <input type="checkbox"/> Open Enrollment	
List all dependents to be enrolled/cancelled		Last Name		First Name		MI	Gender	Date of Birth		Social Security	
<input type="checkbox"/> Spouse <input type="checkbox"/> DEI Adult		<input type="checkbox"/> Add <input type="checkbox"/> Remove					<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove					<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove					<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove					<input type="checkbox"/> M <input type="checkbox"/> F				
If the permanent address of the spouse or child is different from the Employee, Please complete the information below											
Spouse/Child – Full Name			Street Address			City			State	Zip	
Child – Full Name			Street Address			City			State	Zip	
Do you, your spouse or children maintain other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below											
Full Name of Insured			Coverage Type <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V		Insurance Company			Medicare Coverage			
								Part A Effective		Part B Effective	
			<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V								
			<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V								
I have read and understand the conditions, eligibility, & required documentation on Page 3						<b>HR USE ONLY</b>		HRA	Deduction Begin Date		Logged/Faxed to BCBSM
Employee Signature				Date							

**BCN Primary Care Physician Selection**

Last Name	First Name	MI	Social Security Number	BCN Group# <b>00124677</b>	BCN Subgroup#	BCN Class#	Emp ID#
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If you are enrolling in Blue Care Network, you need to select a primary care physician for you and each person on your contract. List your selections on this form. You can choose a different primary care physician for each member of your family, or one to care for your entire family. If you elect to have one doctor for your entire family, you must select a family or general practice physician. You cannot choose a specialist as a primary care physician. You also need to fill out this form if you are already enrolled in Blue Cross or BCN and have decided to change your primary care physician. Need information about available primary care physicians? The website, [bcbs.com/find-a-doctor](http://bcbs.com/find-a-doctor), provides the most current information on BCN-affiliated primary care physicians. You can search for a family practice, general medicine, pediatrics, and preventative medicine.

Member Information						
	Member's last name, first name	Physician last name, first	Physician's NPI#	Physician address	If changing PCPs, list reason	Seen in the last 12 months?
Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 1						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 2						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 3						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dep. 4						<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>I have read and understand the conditions of this form.</b> Employee Signature				Effective Date of change Date:		

**Instructions for completing the BCN Primary Care Physician Selection form:**

- Enter employee's name and social security number (required for all members) of the responsible individual (Example: xxx-xx-xxxx).
- Enter each member's last and first name, physician's last and first name, physician's NPI number. Also enter physician's address and the reason for changing your primary care physician, if applicable. Indicate if the primary care physician has been seen in the last 12 months. You can find the physician's NPI number when searching for a doctor on [bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor) or by contacting the medical office.
- Enter the effective date you changed to this physician.
- In the signature section, sign your full name and enter the date you signed the form.

Note: All changes become effective two business days after this form is received by BCN (unless you request a later date). You cannot select an earlier date when you change your primary care physician. If you change your primary care physician while being treated by a specialist, your new primary care physician must reauthorize the treatment you are receiving. Your treatment may not be covered until that occurs.

## **Please Read – Conditions for Enrollment/Cancellation**

- I hereby authorize my employer or successor to make deductions from my earnings of the required contributions or premiums for the group coverage provided in the policy or policies issued to my employer. Additionally, I understand the contribution for the medical plan is made on a pre-tax basis.
- Note: If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance coverage, you will not be able to enroll again until the next open enrollment period. The only exception by law is a qualified family status change or life event. The enrollment must take place within 31 days of the family change or life event.
- I understand that if my employment is terminated, by voluntary resignation, involuntary resignation, or by any other fashion or method, upon re-employment, coverage will not become effective until I again apply for it in accordance with the terms of the group policy.
- To the best of my knowledge and belief, the information I have provided is complete and correct.

## **Eligibility Definitions**

### **Spouse**

1. The legal spouse of a Subscriber.

### **Dependent Child**

1. Child of a Subscriber by birth; by legal adoption; by legal foster care; or by legal guardianship where the Subscriber is legally obligated by court order to provide health insurance.
2. Child of a Subscriber's spouse by birth; by legal adoption; by legal foster care; or by legal guardianship for whom the Subscriber is legally obligated by court order to provide health insurance.

**NOTE:** A child is considered legally adopted on the date of placement for adoption by an authorized placement agency. A child as defined above is eligible for coverage until the limiting age of 26 under all specified eligibility provisions, or if the child is incapable of self-sustaining employment by reason of a physical or mental disability that was incurred prior to the limiting age and the child is considered a dependent on the Subscriber's federal income tax return.

### **Designated Eligible Individual (DEI)**

An employee who does not already enroll a spouse in health insurance may enroll one adult individual for coverage provided the adult, at the time of proposed enrollment, **resides** in the same residence as the employee and has done so for at least the previous 18 consecutive months. The employee may also enroll a dependent child of an adult DEI provided the child resides with the employee. The employee may not designate his or her IRS dependents, relatives, or tenants. To enroll a DEI, an employee must complete and submit with this form the DEI enrollment form.

### **Family Status Change**

A family status change or life event includes an employee's marriage or divorce, death of a spouse or child, birth or adoption of a child, meeting the DEI requirements, a change in the employee or spouse's employment or an unpaid leave of absence by the employee or spouse.

## **Required Documentation**

### **The following documentation is required for enrollment of a dependent**

1. Spouse – Copy of marriage certificate
2. Child – Copy of the birth certificate, proof of birth document from the hospital, or adoption or foster care placement paperwork
3. Stepchild – Copy of marriage certificate and the child's birth certificate
4. Disabled Child – Doctor's statement that certifies disability
5. Legal Obligation – Copy of the court order to provide health insurance to the specified dependent
6. Legal Guardianship – Copy of the court order entitling the Subscriber to full guardianship of the specified child
7. Designated Eligible Individual – DEI enrollment form and copies of the DEI's federal income tax returns to substantiate residency