Blue Care Network of Michigan

BCN Individual Change of Status Form

Subscriber Name	Group Number	Contract No

Membership Changes (Excludes Medigap)

☐ Add the following person(s) to my contract (must be notified within 30 days of event):
Reason: ☐ Marriage ☐ Birth ☐ Other _____

☐ Remove the following person(s) from my contract:
Reason: ☐ Death ☐ Divorce ☐ 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
A – Child Adoption in Progress (Attach Court Document)
D – Disabled Child (PA275) (Attach Physician Statement)
L – Legal Guardianship (Attach Court Document)
P – Principal Support (Attach Court Document)
C – Court Order Coverage (QMSCO) (Attach Court Document)

Other Changes

☐ New Name

Last Name	First Name	Middle Initial

☐ New Address

Address		
City	State	Zip Code

☐ New Telephone Number

( )

☐ Cancel my BCN 65 prescription drug coverage only.

☐ Cancel my contract on the next scheduled termination date following the receipt of this request. We need 30 days written notification and your signature below to process the contract cancellation.

_____ _____
Subscriber's Signature Date

Agent Code	MA/GA Code	Assn/Chamber	Managing Agent/General Agent/Agent Signature

Fax change request form to 1-877-218-1466

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

WP 11322 NOV 10