



**DIRECT BILLED
ENROLLMENT/CHANGE OF STATUS
HEALTH INSURANCE FORM**

MOA Service Corporation
2445 Woodlake Circle, Okemos, MI 48864
Ph: 800-657-1556; Fax: 517-347-1566

Check One	<input type="checkbox"/> Enrollment Effective Date _____	<input type="checkbox"/> Termination Effective Date _____	<input type="checkbox"/> Address Change <input type="checkbox"/> Reinstatement <input type="checkbox"/> Contract Change <input type="checkbox"/> COBRA				
Subscriber Social Security # _____	Subscriber Last Name _____	Subscriber First Name _____	Middle Initial _____				
Street Address _____ check if new	City _____	State _____	Area Code/Evening Phone _____				
Billing Address, If Any _____	Billing City _____	Billing State _____	Area Code/Day Phone _____				
Employer Name _____	Employer's Contract # _____	Employer's Group # _____	Date of Association Membership or of Employment: _____				
Zip Code _____ County _____ Current Marital Status _____ Billing Zip Code _____ Billing County _____ Single Married							
Mo. / Day / Year							
List all persons to be enrolled/terminated:							
	Circle On	LAST NAME	FIRST NAME	Middle Initial	Sex	Date of Birth MM/DD/YY	Social Security No.
Subscriber	<input type="checkbox"/>						
Spouse	<input type="checkbox"/>						
		Add	Delete				
Dep-1	<input type="checkbox"/>						
		Add	Delete				
Dep-2	<input type="checkbox"/>						
		Add	Delete				
Dep-3	<input type="checkbox"/>						
		Add	Delete				

Do you, your spouse or dependent(s) maintain other health coverage? No Yes If Yes, complete below: Date Coverage Ends: ____/____/____

Person covered (Full Name)	Group	Policy Number	Carrier	Location
Person covered (Full Name)	Group	Policy Number	Carrier	Location

Are you, your spouse or any dependents listed above Medicare eligible? No Yes If Yes, attach a copy of Medicare card(s)

I have read and understand the conditions on the reverse side of this form.

Subscriber Signature _____ Date _____

Are you enrolling as a _____ MOA Member or _____ Employee of MOA Member (please check one)
MOA Member's AOA #: _____

OPT 1: TRADITIONAL _____ OPT 6: COMM BLUE PLAN 8 _____
 OPT 3: CMM \$250 _____ OPT 7: CMM 1500 _____
 OPT 4: CMM \$500 _____ HSA Flexible Blue _____
 OPT 5: COMM BLUE PLAN 1 _____ OPTIONAL VISION: _____

(Available to Options 1, 3, 4 & 5 ONLY)

Group Transfer Update Information (fill in appropriate information):



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Transfer from Option:	Requested Effective Date:	Transfer to Option:
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Please be sure to read the following information before completing the other side of this application.

The information on this form and the following conditions are part of your contract with Blue Cross and Blue Shield of Michigan (BCBSM). You are applying for coverage under your employer's or association's contract with Blue Cross and Blue Shield of Michigan. When BCBSM accepts your application, you and your family are bound by the terms of the policy and this application.

ELIGIBILITY CRITERIA FOR DEPENDENTS OVER AGE 19

Dependent children for family continuation coverage

You may be eligible to obtain coverage for a child between the ages of 19 and 25 if:

1. The child is unmarried
2. The child is a member of the subscriber's household
3. Subscriber provides more than half of the child's support.
4. The child is related to the subscriber by blood, marriage or legal adoption.
5. The child is a full-time student for at least five months of the year or had gross income of less than four times the personal exemption amount identified in the IRS gross income test.

Sponsored dependent coverage

You may be eligible to obtain coverage for the following dependents over 19 years of age:

1. The dependent is not eligible for coverage as a Family Continuation Rider member
2. Subscriber provides more than half of the support for the dependent.
3. The dependent is related to the subscriber by blood, marriage, or legal adoption.
4. The dependent is a member of the subscriber's household.

Disabled dependent coverage

You may be eligible to obtain coverage for an unmarried child who is incapable of self-sustaining employment because of the disability that occurred before age 19. You must supply proof of the disability from a physician licensed in Michigan.

Court ordered coverage

If you have a court order requiring you to provide coverage for a child, BCBSM required a copy of the court order to verify eligibility, determine proper coordination to benefits and provide benefits and information to the child. A court order includes a court approved settlement agreement.

Proof of eligibility

You agree to provide proof of your dependents' eligibility for coverage when requested by BCBSM.

Authorization

You appoint your employer or association to handle all matters of coverage. They may forward any agreed deductions for coverage from your wages.

You are responsible for giving notice to your employer or association of changes in your status and your family's status that affect coverage, such as marriage, births, or death of someone covered under the policy.

You authorize Blue Cross and Blue Shield of Michigan to obtain hospital and medical records about you and your family from health care providers; and you authorize the release of any information needed to process or review a claim.

Release of Information

Blue Cross and Blue Shield of Michigan does not require your Social Security number; however, your employer or association, Medicare, Medicaid, and others BCBSM does business with, do require it.

BCBSM will release information about you only when:

- You request it in writing
- When it must be released to process a claim (e.g., to another insurance company).

Upon your request, BCBSM will tell you where the information was sent.