



MEMBERSHIP AND RECORD CHANGE

When completing this form refer to the instructions on the reverse side.
 GROUPS: Send with statement unless otherwise instructed.

PLEASE PRINT OR TYPE

CONTRACT NUMBER	SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL
SERVICE CODE	SUBSCRIBER'S CURRENT ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS	CITY	STATE ZIP CODE
BADGE NUMBER	GROUP NAME	GROUP NO.	SUFFIX <input type="checkbox"/> OPEN ENROLLMENT

REQUEST FOR MEMBERSHIP CHANGE

ADD MEMBERS TO CONTRACT (ADDITIONS)				SEX	DATE OCCURRED			BIRTH DATE		
					MO.	DAY	YR.	MO.	DAY	YR.
<input type="checkbox"/> MARRIAGE TO	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> BIRTH OF	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> STEPCHILD	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> CHILD BY LEGAL ADOPTION	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> CHILD BY LEGAL GUARDIANSHIP (WARD)	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> PRINCIPAL SUPPORT OF	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.							
<input type="checkbox"/> DCCR <input type="checkbox"/> CHANGE TO <input type="checkbox"/> ADD	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	RELATIONSHIP						
<input type="checkbox"/> FAMILY CONTINUATION <input type="checkbox"/> CHANGE TO <input type="checkbox"/> ADD	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	RELATIONSHIP						
<input type="checkbox"/> SPONSORED DEPENDENT <input type="checkbox"/> CHANGE TO <input type="checkbox"/> ADD	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.	RELATIONSHIP						
<input type="checkbox"/> DISABLED DEPENDENT	LAST NAME	FIRST NAME		RELATIONSHIP						
DIAGNOSIS				DATE CONDITION DEVELOPED				MO.	DAY	YR.
				PHYSICIAN'S SIGNATURE				MO.	DAY	YR.

FOR ANY CHILD NAMED ABOVE, IS THERE A COURT ORDER SAYING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? YES NO FATHER MOTHER IF YES, PLEASE ATTACH A COPY OF THE COURT ORDER.

REMOVE MEMBERS FROM CONTRACT (DELETIONS)				SOCIAL SECURITY NUMBER	DATE OCCURRED		
					MO.	DAY	YR.
<input type="checkbox"/> DEATH OF DEPENDENT	LAST NAME	FIRST NAME	INITIAL				
<input type="checkbox"/> DIVORCE FROM	LAST NAME	FIRST NAME	INITIAL				
<input type="checkbox"/> MARRIAGE OF MINOR OR DEPENDENT	LAST NAME	FIRST NAME	INITIAL				
<input type="checkbox"/> OTHER	LAST NAME	FIRST NAME	INITIAL				

MEDICARE INFORMATION

IS ANY PERSON NAMED ABOVE ENTITLED TO MEDICARE? YES NO IF YES, COMPLETE AND ATTACH MEDICARE INFORMATION FORM # CN 3040

INSURANCE INFORMATION OTHER THAN MEDICARE (TRANSFER INFORMATION)

ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY ANOTHER BCBSM CONTRACT? YES NO CONTRACT NO. _____ GROUP NO. _____

ARE YOU OR ANYONE NAMED ON THIS FORM COVERED BY HEALTH INSURANCE FROM ANOTHER SOURCE? (FOR EXAMPLE, ANOTHER EMPLOYER, SPOUSE'S EMPLOYER, OR CHILD'S NATURAL PARENT) YES NO IF YES, PLEASE COMPLETE BELOW

NAME OF INSURED	CONTRACT POLICY NO.
INSURANCE COMPANY AND ADDRESS	TERMINATION DATE _____ GROUP NO. _____

OTHER			
<input type="checkbox"/> DEATH OF SUBSCRIBER OCCURRED ON	MO. DAY YR.	<input type="checkbox"/> SEND DUPLICATE I.D. CARD	<input type="checkbox"/> CHANGE CONTRACT NO. TO:
<input type="checkbox"/> CHANGE SUBSCRIBER'S NAME TO	LAST NAME	FIRST NAME	INITIAL

ADDITIONAL INFORMATION

VERIFICATION
 I CERTIFY THAT I CAREFULLY AND FULLY READ THE IMPORTANT INFORMATION ON THE REVERSE SIDE, THE STATEMENTS AND ANSWERS GIVEN ARE COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. NO INFORMATION REQUIRED TO BE GIVEN, EITHER EXPRESSLY OR BY IMPLICATION, HAS BEEN KNOWINGLY WITHHELD. I UNDERSTAND THAT BCBSM WILL RELY UPON THE COMPLETENESS AND TRUTHFULNESS OF THE INFORMATION GIVEN AND THE STATEMENTS MADE, THAT IF I HAVE MADE ANY FALSE STATEMENTS OR MISREPRESENTATIONS, OR HAVE FAILED TO DISCLOSE ANY MATERIAL FACT, BCBSM WILL BE ENTITLED TO DECLARE THE HEALTH CARE CONTRACT VOID AND REFUSE ALL ALLOWANCE OF THE BENEFITS TO ANY PERSON UNDER THE CONTRACT.

SUBSCRIBER'S SIGNATURE (DO NOT PRINT) _____ DATE SIGNED _____