Blue Cross Blue Shield Blue Care Network of Michigan

Application for Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan Individual Coverage

(Off Marketplace Only)

This application may be used for coverage through either Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), depending on which medical plan you choose in Section II below. Dental plans or dental with vision, as set forth in Section III, are only offered through BCBSM, but can be paired with BCBSM or BCN medical plans.

Print in black or blue ink or type your information. **All fields are required to be completed unless otherwise noted.** Review your application for completeness and accuracy and sign and date where requested. The information provided will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website **www.bcbsm.com/index/common/important-information/privacy-practices**.

Open Enrollment focuses on 2016 plans. If you would like to apply for a subsidy or tax credit, or if you are 30 or over and would like to check your eligibility for a hardship exemption to enroll in a Catastrophic (Value) Plan please contact a Health Plan Advisor at 1-888-899-3012 or your Blues Agent.

To get individual medical, dental, or dental with vision coverage, you need to be a Michigan resident when your coverage starts. If you're eligible for Medicare you can't be eligible for individual medical coverage.

Section I: Coverage and Enrollment

What kind of coverage are you applying for? (check all that apply)

☐ Medical with Dental & Vision Plan Options
Pediatric vision is included in all medical plans.

☐ Dental or Dental with Vision Plan Options
Medical coverage is required to apply for dental or dental with vision coverage. You have the option to apply for separate medical coverage to qualify for dental or dental with vision.

Who will be covered by this plan?

☐ One adult (individual plan) ☐ Multiple people (family plan) ☐ One child only (be sure to complete the "Child Only Information" section on page 2)

Why are you applying?

☐ Open Enrollment (November 1, 2015 – January 31, 2016)

☐ I have a qualifying event, loss of coverage, or am planning to move to Michigan.
If you're changing your coverage, you'll need to tell us why and provide documentation. You won't be enrolled in your plan until you do. Some common reasons for coverage changes are the birth of a child, marriage, divorce or loss of employer coverage. Here's how to provide documentation:

- Include the documents with this application, or
- Fax the documents to 877-486-2172 and be sure to include your first and last name and phone number when faxing

Please indicate your qualifying event below:

☐ Loss of coverage through job
☐ Loss of coverage because of reduced work hours
☐ Employer ended health care coverage
Name of insurance company _____ Policy number _____
☐ Moved out of plan coverage area
☐ Birth of child
☐ Adoption of child
☐ Marriage
☐ Divorce
☐ Death of previous policy holder
☐ Loss of COBRA benefits
☐ Turning age 26 or no longer on parent's plan
☐ Other (please give details) _____

Date of above event: _____ (please note that you must apply within 60 days of the event)

Your coverage start date will be assigned after we review your application.

Please tell us about the main person applying for this plan. All of your information will be kept confidential and only used for this application.

Last name	First name	M.I.	Suffix	Social Security Number or Personal Tax ID Number	Are you a U.S. citizen or legally present in the U.S.? ☐ Yes ☐ No

Residential address (cannot be a P.O. Box)	City	State	ZIP code	County
Billing address (if different than above)	City	State	ZIP code	County

Email	Primary phone number	Type: ☐ Fax ☐ Home ☐ Cell ☐ Work ☐ Other	Alternate phone number	Type: ☐ Fax ☐ Home ☐ Cell ☐ Work ☐ Other

Gender ☐ Male ☐ Female	Date of birth (if you're under 16, a parent or legal guardian will need to apply for your coverage)	During the past six months, have you been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?* ☐ Yes ☐ No

BCBSM/BCN reserves the right to verify tobacco use and to adjust your premium accordingly. Please see Terms and Conditions for additional information.

Information about your spouse who is applying for this plan**

Last name	First name	M.I.	Suffix	Social Security Number or Personal Tax ID Number	Are you a U.S. citizen or legally present in the U.S.? ☐ Yes ☐ No

Gender ☐ Male ☐ Female	Date of birth	During the past six months, have you been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?* ☐ Yes ☐ No

BCBSM/BCN reserves the right to verify tobacco use and to adjust your premium accordingly. Please see Terms and Conditions for additional information.

****A spouse is the legal husband or wife of the subscriber, as recognized as legal in the jurisdiction where the marriage occurred.***

Information about your dependent children (under age 26 on the policy effective date) who are applying for this plan

Last name	First name	M.I.	Suffix	Date of birth	Social Security Number or Personal Tax ID Number (age one and older, or under age one if available)	Gender	Relationship*	U.S. citizen or legally present in the U.S.?
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No

During the past six months, has any dependent age 18 and older been a regular tobacco user (four or more times per week excluding religious or ceremonial use)? ☐ Yes ☐ No If yes, who? _____

*Dependent Relationship Codes (we reserve the right to audit documentation for all codes except "N")

N – Child (by birth or adoption) P – Principally supported child A – Child adoption in progress S - Stepchild
C – Court ordered coverage L – Legal guardianship D – Disabled child

Child Only Coverage

Please complete this section if you are a parent or legal guardian applying for coverage for a child who will be under age 21 on the policy effective date. A separate application is necessary for each child requiring Child Only coverage.

Child's last name	Child's first name	M.I.	Suffix	Child's Social Security Number or Personal Tax ID Number (age one and older, or under age one if available)	Child's date of birth	☐ Male ☐ Female	U.S. citizen or legally present in the U.S.? ☐ Yes ☐ No

Child's residential address	City	State	ZIP code	County
Legal guardian's name	Legal guardian's primary phone number	Legal guardian's email		
Legal guardian's address	City	State	ZIP code	

During the past six months, has this child (age 18 and older) been a regular tobacco user (four or more times per week excluding religious or ceremonial use)? ☐ Yes ☐ No

Section II: Medical Plan Selection (if applying for dental only or dental with vision please skip to Section III)

Here are your plan choices. Your network of affiliated doctors and hospitals may be different based on the product you choose. Please visit bcbsm.com/networks, or consult your coverage documents, Health Plan Advisor or agent for specific network details. The BCN HMO medical plans are managed care plans; your care will be coordinated by a primary care physician that you select upon enrollment. Learn more about how our networks for doctors and hospitals work at **bcbsm.com/networks**.

If you're interested in our Health Savings Account (HSA) powered by HealthEquity®, just select the HSA option box on any plan that works with an HSA. If you already have our HSA but pick a non-HSA plan, you can still use the money in your HSA account. But you won't be able to add money to that account once your new plan starts.

There is a $2.95* charge per month for our HSA. If you would like to learn more please visit: **www.bcbsm.com/hsa**.

Premiums are charged for the subscriber, spouse, and all adult children age 21 and older and for the three oldest dependent children under age 21. Child Only policies are available on all plans below.

Please select your medical plan from the list below. For plan details and availability please visit **bcbsm.com/myblue**.

**fee is subject to change*

Partnered HMO (BCN Plans)

Gold
- ☐ Blue Cross® Partnered **Gold Extra**
- ☐ Blue Cross® Partnered **Gold**

Silver
- ☐ Blue Cross® Partnered **Silver Extra**
- ☐ Blue Cross® Partnered **Silver**
- ☐ Blue Cross® Partnered **Silver Saver**

Bronze
- ☐ Blue Cross® Partnered **Bronze** (HSA eligible)
  - ☐ Add HealthEquity HSA
- ☐ Blue Cross® Partnered **Bronze Saver** (HSA eligible)
  - ☐ Add HealthEquity HSA

Partnered HMO: You will receive care within the Mercy Health system of doctors and hospitals located in Kent, Muskegon and Oceana counties. Your primary care doctor will coordinate your care. Care within BCN's entire HMO network, but outside the Mercy Health system, will require primary care doctor and plan authorization. Other than eligible emergency services and accidental injuries, care outside BCN's network is not covered. Visit **bcbsm.com/find-a-doctor** to see if your doctor is in the Partnered HMO network.

Metro Detroit HMO (BCN Plans)

Gold
- ☐ Blue Cross® Metro Detroit HMO **Gold Extra**

Silver
- ☐ Blue Cross® Metro Detroit HMO **Silver Extra**
- ☐ Blue Cross® Metro Detroit HMO **Silver**
- ☐ Blue Cross® Metro Detroit HMO **Silver Saver**

Bronze
- ☐ Blue Cross® Metro Detroit HMO **Bronze** (HSA eligible)
  - ☐ Add HealthEquity HSA
- ☐ Blue Cross® Metro Detroit HMO **Bronze Saver** (HSA eligible)
  - ☐ Add HealthEquity HSA

Metro Detroit HMO: You will receive care within a select network of quality doctors and hospitals located in Wayne, Oakland and Macomb counties. Your primary care doctor will coordinate your care. Care within BCN's entire HMO network, but outside the Metro Detroit HMO network, will require primary care doctor and plan authorization. Other than eligible emergency services and accidental injuries, care outside BCN's network is not covered. Visit **bcbsm.com/find-a-doctor** to see if your doctor is in the Metro Detroit HMO network.

Select HMO (BCN Plans)

Gold
- ☐ Blue Cross® Select **Gold Extra**
- ☐ Blue Cross® Select **Gold**

Silver
- ☐ Blue Cross® Select **Silver Extra**
- ☐ Blue Cross® Select **Silver**
- ☐ Blue Cross® Select **Silver Saver**

Bronze
- ☐ Blue Cross® Select **Bronze** (HSA eligible)
  - ☐ Add HealthEquity HSA
- ☐ Blue Cross® Select **Bronze Saver** (HSA eligible)
  - ☐ Add HealthEquity HSA

Catastrophic
- ☐ Blue Cross® Select **Value** (under age 30 before 1/1/16)

Select HMO: You may choose from a select network of quality primary care doctors with complete access to specialists and hospitals within BCN's network, the largest HMO network in Michigan. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Other than eligible emergency services and accidental injuries, care outside the network is not covered. Visit **bcbsm.com/find-a-doctor** to see if your doctor is in the Select HMO network.

Preferred HMO (BCN Plans)

Gold
- ☐ Blue Cross® Preferred **Gold Extra**
- ☐ Blue Cross® Preferred **Gold**

Silver
- ☐ Blue Cross® Preferred **Silver Extra**
- ☐ Blue Cross® Preferred **Silver**

Bronze
- ☐ Blue Cross® Preferred **Bronze** (HSA eligible)
  - ☐ Add HealthEquity HSA

Preferred HMO: You will have a broad choice of doctors and hospitals from BCN's entire network, the largest HMO network in Michigan. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Other than eligible emergency services and accidental injuries, care outside the network is not covered. Visit **bcbsm.com/find-a-doctor** to see if your doctor is in the Preferred HMO network.

Premier PPO (BCBSM Plans)	Metro Detroit EPO (BCBSM Plans)
Platinum ☐ Blue Cross® Premier **Platinum with Dental and Vision** Gold ☐ Blue Cross® Premier **Gold Extra** ☐ Blue Cross® Premier **Gold** Silver ☐ Blue Cross® Premier **Silver Extra** ☐ Blue Cross® Premier **Silver** ☐ Blue Cross® Premier **Silver Saver** (HSA eligible) ☐ Add HealthEquity HSA Bronze ☐ Blue Cross® Premier **Bronze with Primary Care visits** ☐ Blue Cross® Premier **Bronze** (HSA eligible) ☐ Add HealthEquity HSA ☐ Blue Cross® Premier **Bronze Saver** Catastrophic ☐ Blue Cross® Premier **Value** (under age 30 before 1/1/16) **Premier PPO:** You will have a broad choice of doctors and hospitals within BCBSM's unsurpassed statewide PPO network including nationwide coverage. You may receive services from hospitals or doctors outside the network, but you will pay less if you use providers within the network. Visit **bcbsm.com/find-a-doctor** to see if your doctor is in the network.	Gold ☐ Blue Cross® Metro Detroit EPO **Gold Extra** Silver ☐ Blue Cross® Metro Detroit EPO **Silver Extra** ☐ Blue Cross® Metro Detroit EPO **Silver** Bronze ☐ Blue Cross® Metro Detroit EPO **Bronze** (HSA eligible) ☐ Add HealthEquity HSA **Metro Detroit EPO:** You have access to doctors and hospitals in the Metro Detroit EPO network which includes 25 hospitals and more than 6,300 doctors located in Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne counties. Other than eligible emergency services and accidental injuries, you do NOT have coverage if you visit a doctor that is outside of the Metro Detroit EPO Network. Before scheduling an appointment, visit **bcbsm.com/find-a-doctor** to see if your doctor is in the EPO network.

Section III: Dental and Dental with Vision Plan Selection

Under the health care reform law, every health coverage plan needs to cover 10 essential health benefits. Nine of those benefits are included in the medical plan you've chosen. The tenth is for pediatric dental care.

To get this benefit, you need to buy a separate qualified dental plan that covers the pediatric dental essential health benefit. All Blue Cross dental plans include this benefit, and you will have the opportunity to select a dental plan in this application.

If you don't already have a qualified dental plan that has the pediatric dental benefit, you have three choices:

1. Buy a Blue Dental℠ EPO Standard, PPO Standard, PPO Extra, or PPO Plus Standard dental plan which includes the pediatric dental benefit and covers all members on your contract;
2. Buy a Blue Dental℠ PPO Personal Pediatric plan which includes the pediatric dental benefit. If you select this plan, you will only be charged for children under 19 on your contract and only these children will have dental benefits. If you do not have children under the age of 19, you can still meet the pediatric dental benefit requirement at no additional cost by selecting this plan.
3. Buy qualified dental coverage through another insurance carrier.

Which of the following applies to you?

☐ I've already bought a qualified dental plan with pediatric dental coverage.
Insurance Company _____ Policy Number _____

☐ I will have purchased a qualified dental plan with the pediatric dental coverage by the date my medical plan coverage starts.

To learn more about Blue Cross dental plans, talk to your Blue Cross agent or call a Health Plan Advisor at 1-888-899-3012.

You must select one of the options below to continue with your medical coverage plan purchase if you do not already have a qualified dental plan with pediatric coverage or will not have purchased one by the date your medical coverage starts (dental plan descriptions are on Page 5):

2016 Dental Only Plans	2016 Dental with Adult Vision Plans*
☐ Blue Dental℠ PPO Plus Standard	☐ Blue Dental℠ PPO Plus Standard with Vision
☐ Blue Dental℠ PPO Extra	☐ Blue Dental℠ PPO Extra with Vision
☐ Blue Dental℠ PPO Standard	☐ Blue Dental℠ PPO Standard with Vision
☐ Blue Dental℠ EPO Standard	☐ Blue Dental℠ EPO Standard with Vision
☐ Blue Dental℠ PPO Pediatric	N/A

Vision benefits are for non-pediatric (adult) members only. Non-pediatric members are those who are age 19 or older on their plan effective date. Pediatric vision benefits are included in all BCBSM/BCN medical plans. If a member selects a dental with vision plan, it is purchased as a package. Cancellation of either dental or vision coverage will result in cancellation of **both the dental and vision plans.*

Blue Dental℠ PPO Pediatric: You can see any licensed dentist, but you save the most when you stay in network. You have over 280,000 locations to choose from in the Dental Network of America Preferred Network of PPO dentists. Preventive care is covered at 80 percent in network, 50 percent out of network. Visit **mibluedentist.com** to find a dental provider.

Blue Dental℠ EPO Standard: With our lowest price dental plan, you'll need to choose an in-network dentist. Services received out of network are not covered under this plan. But you have over 280,000 locations to choose from through the Dental Network of America Preferred Network of PPO dentists. Preventive care is covered at 80 percent in network. Visit **mibludentist.com** to find a dental provider.

Blue Dental℠ PPO Standard: You can see any licensed dentist, but you save the most when you stay in network. You have over 280,000 locations to choose from in the Dental Network of America Preferred Network of PPO dentists. Preventive care is covered at 80 percent in network, 50 percent out of network. Visit **mibluedentist.com** to find a dental provider.

Blue Dental℠ PPO Plus Standard: You can see any licensed dentist and your percentage of the cost share will be the same. But you'll save the most when you see one of the over 280,000 PPO dentists in our Dental Network of America Preferred Network. Preventive care is covered at 80 percent in network and out of network. Visit **mibludentist.com** to find a dental provider.

Blue Dental℠ PPO Extra: You can see any licensed dentist, but you save the most when you stay in network. You have over 280,000 locations to choose from in the Dental Network of America Preferred Network of PPO dentists. Preventive care is covered 100 percent in network, 80 percent out of network. Visit **mibluedentist.com** to find a dental provider.

Blue Dental℠ EPO Standard with Vision: With our lowest price dental plan, you'll need to choose an in-network dentist. Services received out of network are not covered under this plan. But you have over 280,000 locations to choose from through the Dental Network of America Preferred Network of PPO dentists. Preventive care is covered at 80 percent in network. Visit **mibluedentist.com** to find a dental provider. Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. Visit **vsp.com** to find a vision provider.

Blue Dental℠ PPO Standard with Vision: You can see any licensed dentist, but you save the most when you stay in network. Our Dental Network of America Preferred dental network dentists have over 280,000 locations nationwide. With this plan, preventive care is covered at 80 percent in network and 50 percent out of network. Visit **mibluedentist.com** to find a dental provider. Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. Visit **vsp.com** to find a vision provider.

Blue Dental℠ PPO Plus Standard with Vision: You can see any licensed dentist and your percentage of the cost share will be the same. But you'll save most when you see one of the over 280,000 PPO dentists in our Dental Network of America Preferred Network. Preventive care is covered at 80 percent in network and out of network. Visit **mibluedentist.com** to find a dental provider. Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. Visit **vsp.com** to find a vision provider.

Blue Dental℠ PPO Extra with Vision: You can see any licensed dentist, but you save the most when you stay in network. Preventive care is covered at 100 percent in network and 80 percent out of network. You have over 280,000 locations to choose from in the Dental Network of America Preferred Network of PPO dentists. Visit **mibluedentist.com** to find a dental provider. Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. Visit **vsp.com** to find a vision provider.

Section IV: Additional Information

1. **If applying for a medical plan please answer:**
   Is anyone listed on this application eligible for Medicare? ☐ Yes* ☐ No

   If yes, who? _____

   To be eligible for Medicare under age 65, you need to have one of the following:
   - *A disability and be receiving Social Security disability insurance for more than 24 months*
   - *A diagnosis of end-stage renal disease*
   - *A diagnosis of amyotrophic lateral sclerosis (ALS) as defined by the Center for Medicare and Medicaid Services (CMS)*

   *For more information please visit our Medicare page at **bcbsm.com/medicare.***

   *** If you're eligible for Medicare, you can't apply for individual medical coverage. Please visit bcbsm.com/medicare to learn more.**

2. **If applying for a medical plan please answer:**
   Is anyone listed on this application eligible for Medicaid? ☐ Yes ☐ No

   If yes, who? _____

   *To be eligible for Medicaid, you need to be a Michigan resident and meet the financial criteria of the State of Michigan and the Federal Government. For more information, please visit our Medicaid page at **bcbsm.com/bluecrosscomplete**.*

3. **If applying for a dental or dental with vision plan please answer:**
   Are you or any family members applying for medical coverage or currently active under a medical plan? ☐ Yes ☐ No
   If yes, name of insurance company: _____

   Contract number: _____ Group number: _____

Section V: Optional Information

The following section is completely optional, but your responses will help us develop programs, products and networks that meet our members' needs. Your responses will not impact your health care options or costs in any way.

1. Please pick a primary care physician (PCP) for each family member on your plan**. If you've selected an HMO plan and don't choose a PCP, we will pick one for you and your family members.**

   If you don't know your physician's National Provider Identification (NPI) or other information, you can use our provider directory at **bcbsm.com/find-a-doctor.** To see the nearest pharmacies in your network please visit **bcbsm.com/pharmacy.**

	Physician's First Name	Physician's Last Name	Physician's NPI	Seen in last year?
Applicant				☐ Yes ☐ No
Spouse				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No

2. Have you or any family members applying for coverage been diagnosed with or treated for any of these medical conditions? (do not provide information for any family members who will not be covered under this contract)

   ☐ Yes ☐ No If yes, please check all that apply and list the family member with the condition(s):

√	Medical condition	Name of family member(s) with the condition
☐	Cancer	
☐	COPD/Asthma	
☐	Diabetes	
☐	Mental Health Disorder	
☐	Heart Disorder	

3. My yearly household income is:

   ☐ Less than $30,000 ☐ $45,000 to $70,000 ☐ Greater than $90,000
   ☐ $30,000 to $45,000 ☐ $70,000 to $90,000

4. Race (check all that apply for all family members)

   ☐ White ☐ Filipino ☐ Native Hawaiian
   ☐ Black or African American ☐ Japanese ☐ Guamanian or Chamorro
   ☐ American Indian or Alaska Native ☐ Korean ☐ Samoan
   ☐ Asian Indian ☐ Vietnamese ☐ Other Pacific Islander
   ☐ Chinese ☐ Other Asian ☐ Other

   If Hispanic/Latino, ethnicity (check all that applies for all family members):

   ☐ Mexican ☐ Chicano/a ☐ Cuban
   ☐ Mexican American ☐ Puerto Rican ☐ Other

Section VI: Payment Options

Your security and privacy are important to us. We keep all your personal, medical and financial information confidential and safe using industry-standard certifications and information privacy practices. You can view our privacy statement at **www.bcbsm.com/index/common/important-information/privacy-practices**.

Please tell us how you'll be paying for your first monthly premium. Once you submit this application, you'll be enrolled in your plan. Don't worry; all of your payment information will be kept secure. Acceptable payers are the subscriber, spouse, or when applicable, the parent, blood relative, legal guardian, or other person or entity authorized under the law to pay the premium on the subscriber's behalf.

1. Who will pay the premium for this policy?

☐ Self ☐ Employer ☐ Health Care Provider
☐ Legal guardian ☐ Family member ☐ Other (please specify) _____

2. How do you want to pay your initial premium?

☐ Electronic Fund Transfer (EFT); please complete section below
☐ Bill me

If you selected a BCBSM plan and have chosen to submit your first payment automatically, your payment will be deducted 2-3 days after your application is approved. All future premium bills will be mailed directly to you.

If you selected a BCN medical plan, new Auto-Draft setups must be completed 3 business days before the due date in order for the first payment to be deducted approximately the 25th of the month before your plan effective date.

Note: You will be sent a monthly bill for future premium payments for all plans.

Electronic Fund Transfer (EFT) automatically deducts your premium payment from an account you designate.

Full Name (First, Middle, Last)			
Residential Address	E-Mail Address		
City	State	Zip Code	Primary Phone Number
Name of Financial Institution	Type of Account ☐ Checking ☐ Savings		
Bank Account Number	ABA/Routing Number (9 digits)		

Automatic payment cannot be processed without your signature. I authorize Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network (BCN) to deduct this one time payment from the bank account listed above.

Signature _____ Date _____

Section VII: Consent, Terms and Conditions

BLUE CROSS BLUE SHIELD OF MICHIGAN OR BLUE CARE NETWORK OF MICHIGAN PLANS

I understand that I am eligible for this coverage if I, my spouse and my dependents are residents of Michigan on the effective date of the policy, and that I, my spouse and my dependents are not eligible for or enrolled in Medicare. I certify that I, my spouse and my dependents are U.S. citizens or legally present in the U.S.

If I am applying for coverage outside of the open enrollment period, I certify that I meet one of the qualifying events defined by the Affordable Care Act (ACA). I am applying for health coverage through Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), based on the specific plan(s) I selected, and understand that I will be subject to the terms and conditions of this application, and I agree that I will also be bound by all provisions in the applicable plan certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable. Additional information may be required of me. Coverage is contingent on timely payment of premium.

I certify that the requirements of eligibility are met and that all of the information supplied on this application is true, correct, and complete to the best of my knowledge. I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation and/or false or misleading information may result in termination or rescission of coverage.

BCBSM or BCN, as applicable, has the right to test for tobacco usage in order to determine applicable rates, and that BCBSM or BCN, as applicable, can retroactively adjust premium rates back to the effective date based on results of tobacco (cotinine) testing. Regular tobacco use is defined as four or more times per week excluding religious or ceremonial use. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

This coverage is not an employer group health plan and is not intended in any way to be an employer-sponsored health insurance plan. I certify that neither my or my spouse's employer will contribute any part of the premium, nor will I or my spouse be reimbursed for any part of the premium by the employer now, or in the future.

I may enroll my eligible spouse and eligible dependents. A dependent child is related to the subscriber by birth, marriage, legal adoption or legal guardianship and under the age of 26 on the coverage effective date. I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own individual coverage. Disabled, unmarried children may remain covered after they turn 26 if certain requirements are met.

With regard to costs of hospital and medical services delivered by or paid for by BCBSM or BCN, as applicable, I agree to assign my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under Worker's Compensation laws or acts whether by redemption award or voluntary payment or otherwise to BCBSM or BCN, as applicable.

CANCELLATION OF EXISTING BCBSM OR BCN COVERAGE OR PRIOR APPLICATIONS

In applying for coverage, I am requesting cancellation of any other BCBSM and BCN individual policy or prior application for coverage whether BCBSM or BCN for which I am a contract holder and lists the same covered members (if any) for which I have requested coverage with this application; and, that the policy cancellation be effective as of the effective date of this coverage and prior applications whether BCBSM or BCN be cancelled immediately. If I want to maintain my existing coverage when the coverage for which I am applying becomes effective, I will contact BCBSM/BCN directly in writing making such a request, and will include a copy of this application with my written request.

HEALTH SAVINGS ACCOUNT OFFERED THROUGH HEALTH EQUITY®
Formerly known as the "Healthy Blue℠ HSA," customers enrolled in HSA eligible plans can pair their plan with a health savings account (HSA) offered through HealthEquity. HealthEquity is an independent company partnering with Blue Cross Blue Shield of Michigan and Blue Care Network to provide health care spending account administration services. An independent and FDIC-insured bank holds the health savings account dollars.

HSA accounts will be charged a $2.95* per month administrative fee per funded account. The fee will be deducted from your health savings account balance. If you do not have an account balance, you will not be charged the monthly fee. Members with Native American cost-sharing subsidies on any plan cannot open an HSA. Likewise, Blue Cross plans that are not High Deductible Health Plans (HDHP) are not eligible to open an HSA account, this includes Blue Cross Plans with "extra" benefits, as some benefits are covered before the deductible is met. If you have already established an HSA and begin to receive these cost-sharing subsidies, or if you switch to a non-HDHP with BCBSM, BCN, or another insurer, you will continue to own the funds in your HSA and may continue to spend from your HSA but you will no longer be able to contribute to and manage your HSA through BCBSM's/BCN's member portal at bcbsm.com. BCBSM/BCN will notify HealthEquity of your ineligibility and you will receive information within one month of the date of ineligibility on how to continue managing your health savings account.

Customers who have an HSA with HealthEquity through their current BCBSM or BCN HDHP and apply for another HDHP with either BCBSM or BCN will continue to be able to manage their HSA through the BCBSM/BCN member portal. If you want to discontinue management of your HSA with HealthEquity through the BCBSM/BCN member portal you must contact BCBSM/BCN customer service directly to decouple management of your HSA from your Blue Cross plan.

*fee is subject to change

CATASTROPHIC (VALUE) PLANS
Catastrophic plans including Blue Cross® Premier Value PPO and, Blue Cross® Select Value HMO are available to individuals under the age of 30 or those that have received a certification of exemption from the individual mandate due to affordability or hardship from the Health Insurance Marketplace. All members on the plan, including your spouse and dependents, must be under age 30 before the plan year begins January 1, to be eligible to enroll in a catastrophic plan. If you meet this eligibility requirement, you can stay in a catastrophic plan for the duration of the calendar year.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
I understand that information collected about me, as provided by this authorization, will be used for the purposes noted below as well as to determine my eligibility for health coverage. BCBSM or BCN may collect personal and protected health information (PHI) about me in order to process my application for coverage. BCBSM or BCN will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on **bcbsm.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on BCBSM's and/or its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN. My authorization includes disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This PHI is to be disclosed so that BCBSM or BCN may: (1) perform case, care and disease management, (2) validate rating factors allowable under the Patient Protection and Affordable Care Act (PPACA), (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (4) for other legally permissible purposes, including but not limited to, healthcare operations.

If BCBSM re-discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information and if I provide this authorization, information may be re-disclosed by the recipient and is no longer protected. I understand and acknowledge that if I am applying for coverage from BCN that this restriction on re-disclosure does not apply, but if BCN does re-disclose my information it may no longer be protected.

I understand that my enrollment with BCBSM or BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM or BCN and its subsidiaries and from any of the parties listed above to BCBSM or BCN. A copy or other reproduction of this authorization shall be valid as the original. My authorization expires upon the later of (i) rescission or rejection of coverage by BCBSM or BCN; or (ii) I cause my coverage to terminate or it otherwise expires. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **www.bcbsm.com** or by contacting my agent. I understand that revocation will not affect actions taken before BCBSM or BCN or any of the parties identified above receive my request

REFUND POLICY
I understand that if I terminate coverage, BCBSM or BCN will refund the unused portion of the monthly premium that was paid. BCBSM or BCN will mail me a check within 30 days from the date of my termination.

If I select a BCBSM plan, I may terminate my coverage by notifying BCBSM within 10 days of the effective date of my coverage. I will receive a full refund of my premium. If I terminate my coverage after 10 days, I will receive a pro-rated refund on the unused portion of my premium.

Section VII: Sign and Date

Please review your application for completeness and accuracy, and sign and date below. A dated signature is required for each applicant age 16 and older.

I understand that a Summary of Benefits and Coverage (SBC) related to the coverage for which I am applying is available on the web at: **bcbsm.com/sbc**. I understand the SBC is not a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the SBC and my applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the SBC electronically via the website. I understand a paper copy is also available, free of charge, by calling BCBSM at 1-888-288-2738 or BCN at 1-800-662-6667, as applicable (both numbers are toll free).

If I selected one of BCN's HMO medical plans, I may cancel this agreement within 72 hours after signing. Any premium payment made will be refunded within 30 days of receipt of my notice of cancellation. I shall be responsible for payment of reasonable fees for any services received during the 72 hours and these may be deducted from my premium payment before the refund is made.

Signature of Applicant (if child only policy, legal guardian must sign)	Date
Signature of Spouse	Date
Signature of Dependent (age 16 or older)	Date
Signature of Dependent (age 16 or older)	Date

Mail your completed application to:

Individual Business
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd, Mail Code 609G
Detroit, MI 48226
Or fax to: 877-486-2172

Area Below for Agent Use Only

Agent first name	Agent last name	5 digit agent code
MA/GA name	Association/Chamber name	

Name of person entering enrollment information online
First name Last name

Date producing agent accepted paper enrollment form from individual	Date ___ / ___ / _____ (mm/dd/yyyy)
Date managing or general agent or association received paper enrollment from agent	Date ___ / ___ / _____ (mm/dd/yyyy)
Agent signature	Date signed