PLEASE PRINT CLEARLY

Application for Individual Coverage

Group Conversion ☐ Nongroup ☐

Shaded Areas are for **BCBSM Use Only**

Select One Option: **Option A** ☐ **Option B** ☐ **Option C** ☐ **Option D** ☐ **Option E** ☐ **Young Adult Blue** ☐ **Value Blue** ☐ **PPO Blue Plus** ☐ **PPO BlueBasic** ☐ **Young Adult Blue PPO** ☐ **Value Blue PPO** ☐ **Individual Care Blue** ☐

Social Security Number	Group Number	Service Code	Eff. Date: MMDDYYYY	U/W:	Preex Date

Current Contract Number	Your Last Name	First Name	Initial	Date of Birth MM/DD/YYYY	☐ Male ☐ Female	☐ Single ☐ Married

Street Address	City

State	Zip Code	County	Telephone Number with Area Code

How long have you lived at your present address? ____________ How many months each year do you reside at this address? ______

If you do not reside in Michigan at least six months a year, you are not entitled to this coverage.

If you wish to apply for coverage for a spouse and/or unmarried children who are under age 19 or who will turn 19 this year, please list them below. Provide last name only if different from yours.

Last name (Spouse)	First Name	Sex	Birth Date MM/DD/YYYY	Social Security Number	Preex Date
Last name (Child/Dependent)	**First Name**	**Sex**	**Birth Date MM/DD/YYYY**	**Social Security Number**	**Preex Date**
Last name (Child/Dependent)	**First Name**	**Sex**	**Birth Date MM/DD/YYYY**	**Social Security Number**	**Preex Date**
Last name (Child/Dependent)	**First Name**	**Sex**	**Birth Date MM/DD/YYYY**	**Social Security Number**	**Preex Date**

If you wish to apply for coverage for unmarried children who are age 20-25 this year, please list them below. Provide last name only if different from yours.

Last name (Child/Dependent)	First Name	Sex	Birth Date MM/DD/YYYY	Social Security Number	Preex Date

Individuals enrolled in Medicare are not eligible to enroll in this coverage.

Member's First Name	Employer	Coverage Provided By: Carrier	Date Coverage Expires	Contract Number

1. Are you currently active under an active Blue Cross Blue Shield of Michigan group health plan? Yes ☐ No ☐
   If Yes, when will your current policy terminate? ____________________
2. Are you or any family members applying for coverage eligible for, or currently active with:
   - Medicare or other group-sponsored health insurance? Yes ☐ No ☐
   - Individual insurance? Yes ☐ No ☐ If yes, when will your current policy terminate? ____________________
3. Will your current employer contribute toward or reimburse you for any portion of your individual coverage? Yes ☐ No ☐
4. Would you like to be reviewed to determine eligibility for the waiver of the preexisting exclusion period according to the criteria listed on the back of this application? Yes ☐ No ☐ (If yes, please attach any documentation to the application which could verify your eligibility including certificates of creditable coverage.)

I am applying for Blue Cross Blue Shield of Michigan (BCBSM) Nongroup or Group Conversion coverage as indicated subject to the terms and conditions in the material that accompanied this application and I agree that I and my covered dependents will be bound by all provisions in the BCBSM certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills. I certify that the requirements of eligibility are met and that the information I have given on this application is true and correct to the best of my knowledge. I authorize BCBSM to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCBSM has the right to use and disclose these records and other confidential member information for valid business purpose.

Agent I.D. Number	MA Code	Signature of Applicant	Date
		Signature of Agent	Date

Please submit two month payment for Individual Care Blue only.

For **BCBSM Use Only** Managing Agent Code ____________________ Agent ID # ____________________ Badge # ____________

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

Waiver of Preexisting Exclusion

To be eligible for a waiver of the preexisting condition exclusion in BCBSM non-group coverage, you must meet all of the following criteria:

- Prior to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, or other health plans. Freestanding benefit programs, such as dental and vision coverage, cannot be counted as prior health care coverage.

- Your most recent health coverage must have been through a group health plan. (Please note that even though health coverage might be provided through an association or other organizations, it is considered to be "individual" health insurance if it is not provided through an employer-sponsored group health plan. Also, a business owner and spouse are not considered employees of a business if no other employee partakes in the health plan. If this is the case, the health plan cannot be defined as a "group" health plan but is instead an individual health plan.)

- You have elected and exhausted any COBRA coverage for which you were eligible.

- You are no longer eligible for group coverage and you are not eligible for Medicare or Medicaid.

- Your prior coverage was not terminated due to premium nonpayment or fraud.

If you believe you meet these criteria, please attach all documentation that verifies this and check "Yes" on the other side of this application under question #4.

If you are enrolling through an independent agent you must submit your application directly to your agent so that they can process the application through the appropriate Managing Agent office.

If you are enrolling direct with BCBSM, please mail your completed application to:

Attention: Underwriting, M.C. B576
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-9942

Or Call: 1-800-848-5101