Macomb Community College
Education • Enrichment • Economic Development
Discover. Connect. *Advance.*℠

Blue Cross Blue Shield Blue Care Network of Michigan

Enrollment Application – BCBS/BCN

Please check the box next to the plan you are choosing:					
☐	HDHP	☐	HMO	☐	PPO
Effective Date:					

1. Participant Information

Employer Macomb Community College ID# _____

Last Name _____ First Name _____ Initial _____

Social Security Number _____ ☐ Female ☐ Male Date of Hire/Rehire _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____ Bargaining Unit _____

2. Insurance Information

Are you or any of your dependents covered by any other medical coverage? ☐ Yes ☐ No

If yes, please check those who have such coverage: ☐ Self ☐ Spouse ☐ Child(ren)

Name of Carrier _____ Policy # _____

Type of Coverage _____

Are you or a dependent Medicare eligible? ☐ Yes ☐ No If yes, effective dates: Part A _____ Part B _____

Medicare Eligible Last Name _____ First Name _____ Initial _____

3. Dependents

Are you under court order to provide health coverage? ☐ Yes ☐ No

Below, list all dependents that will be covered:

	Last Name	First Name	Middle Initial	Check One F=Female M=Male	Date of Birth	Social Security Number	ID Number (HR ONLY)
Spouse				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature _____ Date _____