Michigan State Plan Enrollment Form - (Pre 65)

1. Name: _____ _____ _____
   First Name *Middle Name* *Last Name*

   Address _____ _____ _____
   Street *City* *State*

2. Date of Birth: ____ ____ ____
   MM *DD* *YY*

   _____ _____
   Telephone Number *Email Address*

   ☐ Male ☐ Female
   Gender

   Insurance Start Date: ____ ____ ____
   MM *DD* *YY*

   _____
   Name of Company Resident From

   DOB of Eligible Resident ____ ____ ____
   MM *DD* *YY*

   _____
   Name of Eligible Resident

Please complete your information, sign and return.

Medical carriers offered: Blue Cross Blue Shield
Members: Resident, Spouse/Domestic Partner, Surviving Spouse or Dependent have the ability to enroll individually in coverage as a Single person if they desire.

*Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a qualifying member and/or Spouse and/or Dependent enrolling in the plan as a Family. If two (2) people are enrolling in the plan, selecting enrollment as a single on two (2) forms (*offers better pricing*). The two family members are not required to have the same coverage if they enroll individually. Each family member must complete their own form and send payment individually for their plan options.

THE HCTC PROGRAM HAS NOT BEEN EXTENDED. ALL PLAN PARTICIPANTS WILL HAVE TO PAY 100% OF THE PLAN PREMIUM UNLESS/UNTIL THE HCTC PROGRAM IS EXTENDED

3. Type of Enrollment

   ☐ New Enrollment (Bundled Medical, RX, Dental & Vision

4. Change of Status

   ☐ Address Change ☐ Terminate Coverage

   ☐ Add Dependent Other _____

5. Enrollee Information

   ☐ Resident of Michigan

   ☐ Resident of Michigan and Family (3+)

6. Plan Options - Blue Cross Blue Shield Plans

BUNDLEDPLANOPTIONS

Medical,RX,Vision&HighDentalPlan

☐ New Enrollment COMMUNITY BLUE Plan
☐ New Enrollment SIMPLY BLUE Plan
☐ Terminate (COMMUNITY PLAN)
☐ Terminate (SIMPLY BLUE PLAN)

By signing below you are also agreeing to the Terms and Conditions.

7. Signature _____ Date of Signature _____ *MM* *DD* *YY*

❒ Terms & Conditions

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan.

I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross. Coverage begins on the date determined by Blue Cross. When the carrier(s) accept(s) my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by Blue Cross Blue Shield of Michigan.

Authorization: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize Blue Cross and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of mine/our medical care, administration of my coverage with Blue Cross and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and/or my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to Blue Cross for purpose of administering our coverage.

Instructions for Completion and Submittal of ALL Forms

Complete form by printing a blank form and filling in all necessary information.

Contact Benistar with any question 1-800-236-4782

Completed forms can be faxed or emailed to Benistar at: memelig@benistar.com
Or if faxing send to: 1-860-408-7025

If mailing send to:
Benistar Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001

Cnvf!Dsptt!Cnvf!Tijfne!ñ!Nfejdbm!Qmbo!Pqujpot!

Pre 65 / 2024 Rates

COMMUNITY BLUE PLAN	
Single	%!2-:16/:1!
Family	%!6-755/87!

SIMPLY BLUE PLAN	
Single	%2-443/18!
Family	%4-:54/39!

Coverage Contact Information

Benistar

Phone: 1(800)236-4782

Your Call Center and Plan Administrator

Mailing Address for Enrollment Forms :
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001
(do not send checks to this address)

Fax Enrollment Forms:
(860)408-7025

Medical Plan Information:

Blue Cross Blue Shield Medical Plans

Blue Cross Blue Shield of Michigan	
Post-Enrollment Benefits and Claims	
Benistar Call Center	(800)236-4782
BCBSM Claims Department	(877)354-2583

Prescription Drug Plan Information:

Blue Cross Blue Shield Prescription Drug Plans

BCBSM Pre-Enrollment Benefit Inquiries:	(800)236-4782
Post-Enrollment Benefits & Claims	
Prescription Drug Formulary	(877)354-2583

Dental Plan Information:

Blue Cross Blue Shield Nationwide Plans (Dental)

Blue Cross Blue Shield of Michigan	
www.Mibluedentist.com	
Dental Customer Service Find a Doctor	(888)826-8152

Vision Plan Information:

Blue Cross Blue Shield Michigan (Blue Vision VSP with BCBSM)

BCBSM Customer Service	(800)877-7195
www.VSP.com or www.BCBSM.com	

All billing / payment information will be listed on your Benistar invoice.