

QuotesforMedical.com

Application Instructions for Blue Cross Blue Shield of Michigan

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to QuotesforMedical.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to QuotesforMedical.com along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Blue Cross Blue Shield of Michigan** if you are not paying by credit card for the first month.

Mail completed applications and check to:

QuotesforMedical.com
Attn: New Enrollment
100 W. Roosevelt Rd
Bldg 8, Ste 103A
Wheaton, IL 60187

QuotesforMedical.com will review your application for completeness and accuracy before we submit it to Blue Cross Blue Shield of Michigan for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-866-522-5953 or e-mail us at info@QuotesforMedical.com.

Norvax form #IN-1

QuotesforMedical.com

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

QuotesforMedical.com

FAX# 630-480-3346

Dear QuotesforMedical.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact QuotesforMedical.com at 1-866-522-5953 to verify receipt of my application.

****I understand that QuotesforMedical.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to QuotesforMedical.com. :

QuotesforMedical.com

Attn: New Enrollment

100 W. Roosevelt Rd

Bldg 8, Ste 103A

Wheaton, IL 60187

I will send the original, signed application and premium payment, as soon as I have been contacted by QuotesforMedical.com with confirmation that my application has been received by fax and reviewed for completeness.



Individual and Direct Billed Enrollment Application

Choose your health plan:

- Value BlueSMPPO
- Value BlueSMTraditional
- Young Adult BlueSM Traditional
- Young Adult BlueSM PPO

- Individual Care BlueSM PPO
- Flexible BlueSM 1500
- Flexible BlueSM 2500
- Optional Dental
- Optional Maternity

PLEASE PRINT CLEARLY

To be eligible for this coverage, you must reside in Michigan at least six months a year and cannot be enrolled in Medicare.

Requested Coverage Start Date
(N/A if you answered "Yes" to question 2.)
MMDDYYYY

Your Last Name	First Name	Initial
<input type="text"/>	<input type="text"/>	<input type="text"/>

- Must be Future Date

Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number	Telephone Number with Area Code	Date of Birth MM/DD/YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	

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 if different from yours. (Please use an additional sheet of paper for more than three children.) Spouses and dependent children are not eligible for Young Adult Blue. If you need family coverage, Individual Care Blue or Value Blue may be better options.

Last name (Spouse)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

If you wish to apply for coverage for an unmarried child who is age 20-25 this year, please complete below. Provide last name if different from yours. (Please use an additional sheet of paper for more than one child.)

Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

- I live in Michigan six or more months each year: Yes No
- Are you currently active under a Blue Cross Blue Shield of Michigan (BCBSM) employer-sponsored group health plan or have you left a BCBSM employer-sponsored group health plan within the last 60 days? Yes No

If yes, please provide your:

Contract Number	Group Number	Policy End Date MM/DD/YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

- Are any individuals listed above:
 - Enrolled in Medicare? Yes No
 - Eligible for or enrolled in a group-sponsored health plan? Yes No If yes, when will your current policy terminate?
 - Enrolled in an individual (non group) health Plan? Yes No If yes, when will your current policy terminate?

4. Does your employer pay for or reimburse you for all or part of your health care coverage or provide you with a health care plan? Yes No

I am applying for BCBSM coverage 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.

Area below for BCBSM Use Only			Signature of Applicant		Date
Agent Code	MA/GA Code	Assoc./Chamber Code	Agent's Signature		Date
16038	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>

Group Number	Service Code	Eff.Date: MMDDYYYY	U/W:	Preex Date	DEID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

BCBSM Pre-existing Condition Waiting Period

If you have a pre-existing condition, there may be an initial 180-day waiting period from the start date of your coverage for which related claims may not be reimbursable. You may be eligible to waive the pre-existing condition waiting period associated with BCBSM non-group coverage (including any limitation on pregnancy benefits) if you meet all of the following criteria:

- Immediately preceding 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, freestanding prescription drug coverage or other health plans. Freestanding dental and vision coverage, workers compensation or automobile insurance 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 usually not considered employees of a business if no other employee participates 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 plan. If, however, the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan. Proof may be required of employee status.)
- 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.
- Your prior coverage was not terminated due to premium nonpayment or fraud.

When your application is processed, you will receive a welcome letter that further explains waiving the pre-existing condition waiting period.

Check List for Submitting Your Application

- Review your application for completeness and accuracy.
- Sign and date your application.
- Submit your application (page 1 of 3) and Automatic Payment Plan enrollment form (page 3 of 3) as follows:
 - If you are enrolling through an independent agent, submit your application directly to your agent so that he or she can process the application for you
 - If you are enrolling directly with BCBSM, please mail your completed application to:

**Blue Cross Blue Shield of Michigan - MC B576
600 E. Lafayette Blvd.
Detroit, MI 48226-2298**

After your application is reviewed and approved, you will receive a bill. A start date for your coverage will be assigned as close as possible to the date you requested on the application (page 1 of 3) or as close as possible to the “Policy End Date” indicated in question 2 (on page 1 of 3). Your coverage will become effective upon receipt of payment.

Questions: 888-642-2276

