



Administered by Blue Cross Blue Shield of Michigan, an independent licensee of the Blue Cross and Blue Shield Association.

**CHECK APPLICABLE BOX**

ENROLLMENT     REINSTATEMENT     TRANSFER  
 ADDRESS CHANGE     CONTRACT CHANGE     RETIREMENT  
 TERMINATION     COBRA     DEATH OF SUBSCRIBER  
 WAIVED COVERAGE

**NASCO-NATIONAL ACCOUNTS**  
**BLUE CROSS BLUE SHIELD**  
**BENEFIT ENROLLMENT/CHANGE FORM**

**SHADED AREA IS FOR EMPLOYER USE ONLY**

Subscriber Social Security #		Subscriber Last Name		Subscriber First Name		Subscriber Telephone		Subscriber Email Address		Group Number		Group Section		Department Number		Effective Date		
Street Address		City		State		Zip Code		Country (if other than USA)		Package Code		Date of Birth		Date of Hire		Plan Code		
<p>Check if new <input type="checkbox"/> Check if Name Change <input type="checkbox"/></p>																		
<p>List all persons to be enrolled or terminated:</p>																		
Circle One	LAST NAME	FIRST NAME	MI	X	S	DATE OF BIRTH	RC	EO	LD	E	SOCIAL SECURITY #	Med	Dental	Vision	Drugs	Med. A Eff. Date	Med. B Eff. Date	HIB#
Subscriber						MM/DD/YYYY												
Spouse	Add	Delete																
Dep-1	Add	Delete																
Dep-2	Add	Delete																
Dep-3	Add	Delete																
Dep-4	Add	Delete																

**Other Coverage**

Do you, your spouse or dependent(s) maintain other health care coverage?  YES  NO

If you checked YES, you must complete the Enrollment Application Coordination of Benefits Health Coverage form (CF0249 APR 04) and attach it to this form.

If you checked NO, proceed to Section 4 of this form.

**Signature**

The information I have submitted is full, complete and true to the best of my knowledge. I understand that any false statements may result in the loss of this coverage.

In addition, I authorize deductions from my earnings of the required contributions, if any, toward the cost of coverage.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

**If Applicable: Blue Healthcare Bank Option - Complete the following additional information**

Add    Effective Date     HRA Health Reimbursement Arrangement     LPHRA-B Limited Purpose Health Reimbursement Account    Goal Amount\*  
 Change    /    /     FSA Health Flexible Spending Account     DCFS-A-B Dependent Care Flexible Spending Account  
 Cancel     HSA Health Savings Account     LPHSA-B Limited Purpose Flexible Spending Account

\* Total annual dollar amount employee will contribute to the applicable FSA account.

**FOR GROUP USE ONLY**

Additional Blue Healthcare Bank option: \_\_\_\_\_

Return completed form to: Blue Cross Blue Shield of Michigan, 600 E. Lafayette Blvd, MC B340, Detroit, MI 48226. Please keep the pink copy for your records.

CN 3499 OCT 07    WHITE PLY - RETURN TO BCBSM    YELLOW PLY - GROUP    PINK PLY - SUBSCRIBER