BCS LIFE INSURANCE COMPANY

MEMBERSHIP AND RECORD CHANGE FOR MEDICALLY UNDERWRITTEN CONTRACTS

MDA Insurance

When completing items with * refer to the Instructions on Page 2. View Instructions

CONTRACT NUMBER	LAST NAME	FIRST NAME	INITIAL

SERVICE NUMBER	CURRENT ADDRESS IF NEW CHECK HERE ☐	CITY	STATE	ZIP CODE

COUNTY CODE	COUNTY NAME	HOME PHONE NUMBER	WORK PHONE NUMBER	GROUP NUMBER	SUFFIX

REQUEST FOR MEMBERSHIP CHANGE

Office Use Only

ADD MEMBERS (ADDITIONS) — IF PREVIOUS BCBSM COVERAGE, PLEASE INDICATE PRIOR GROUP AND CONTRACT NUMBER IN ADDITIONAL INFORMATION AREA	LAST NAME	FIRST NAME	INITIAL	*SOCIAL SECURITY NO. (MANDATORY)	Date Occurred MM/DD/YY	Birth Date MM/DD/YY	SEX M	SEX F	Pre- Existing End Date MM/DD/YY
☐ *MARRIAGE TO							☐	☐	
☐ *BIRTH OF							☐	☐	
☐ *STEPCHILD							☐	☐	
☐ *CHILD BY LEGAL ADOPTION							☐	☐	
☐ *CHILD BY LEGAL GUARDIANSHIP (WARD)							☐	☐	
☐ *PRINCIPAL SUPPORT OF							☐	☐	
☐ *OTHER							☐	☐	

ADDITIONAL INFORMATION

FOR ANY CHILD NAMED ABOVE, IS THERE A COURT ORDER SAYING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? ☐ YES ☐ NO ☐ FATHER ☐ MOTHER IF YES PLEASE ATTACH A COPY OF THE COURT ORDER.

REMOVE MEMBERS (DELETIONS)	LAST NAME	FIRST NAME	INITIAL	*SOCIAL SECURITY NO. (MANDATORY)	Date Occurred MM/DD/YY
☐ *DEATH OF DEPENDENT					
☐ *DIVORCE FROM					
☐ *MARRIAGE OF MINOR OR DEPENDANT					
☐ *OTHER					

ADDITIONAL INFORMATION

REQUEST FOR RECORD CHANGE

☐ ENROLL THE FOLLOWING MEMBERS IN THE PROPER SUPPLEMENTAL COVERAGE:	FIRST NAME	INITIAL	Birth Date MM/DD/YY	TAKE THIS INFORMATION FROM YOUR MEDICARE CARD — MEDICARE NUMBERS	EFFECTIVE DATE HOSP. INS. MM/DD/YY	EFFECTIVE DATE MED. INS. MM/DD/YY
SUBSCRIBER'S LAST NAME						
SPOUSE'S LAST NAME						
OTHER LAST NAME						

☐ *CHANGE NAME TO — LAST NAME / FIRST NAME / INITIAL

☐ CHANGE CONTRACT NUMBER TO:

☐ *DEATH OF SUBSCRIBER OCCURRED ON → MM/DD/YY

☐ REFUND/BILL FAMILY AT THE ABOVE ADDRESS

☐ I HEREBY REQUEST CANCELLATION OF COVERAGE → SUBSCRIBER'S SIGNATURE

☐ *OTHER ARE YOU OR YOUR DEPENDENTS CURRENTLY COVERED BY ANOTHER BCBSM CONTRACT? ☐ YES ☐ NO IF YES COMPLETE NEXT LINE

*NAME	CONTRACT NUMBER	GROUP NUMBER

Change deductible from $_____ to $_____ effective _____. Note: Your deductible starts over when you change benefit plans. If you change to a lower deductible plan your application is subject to Medical Underwriting.

SPECIAL REQUEST

☐ *SEND DUPLICATE I.D. CARD After Completion

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND BELIEF:

SUBSCRIBER'S SIGNATURE	DATE	WITNESS SIGNATURE	DATE

PLEASE RETURN TO: MDA INSURANCE & FINANCIAL GROUP INC.
3657 Okemos Road, Suite 100
Okemos, MI 48864

FOR UNDERWRITER/ADMINISTRATOR USE ONLY

EFFECTIVE DATE	SERVICE CODE

INSTRUCTIONS

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THIS FORM IS FOR REPORTING MEMBERSHIP AND RECORD CHANGES TO BCS LIFE INSURANCE COMPANY, IN KEEPING WITH REGULATIONS DETAILED IN THE GROUP CONTRACT, INDIVIDUAL CERTIFICATE AND IN THE GROUP OPERATING MANUAL. PLEASE PRINT OR TYPE ALL INFORMATION ENTERED ON THE FORM. PREPARE IN DUPLICATE, KEEPING COPY FOR GROUP'S FILE OR FOR INDIVIDUAL (WHICHEVER IS REQUIRED).
THE SIGNATURE AND DATE MUST BE ENTERED ON THE FORM WITHIN 30 DAYS OF THE EVENT AS DESCRIBED BELOW. SEND TO BLUE CROSS AND BLUE SHIELD OF MICHIGAN AS ADMINISTRATOR FOR BCS LIFE INSURANCE COMPANY.

REQUEST FOR CHANGES IN MEMBERSHIP	
ADDING MEMBERS (ADDITIONS)	
SOCIAL SECURITY NUMBER	*Social Security number mandatory for each member. Application will be returned if missing. If adding a newborn to coverage, please write "pending" and forward new social security number when it is obtained.*
MARRIAGE	*Report addition of wife/husband within 30 days of event. May sign 30 days before marriage.*
CHILD BY BIRTH	*Report within 30 days of birth date.*
STEPCHILD	*Report within 30 days of marriage. May sign 30 days before marriage.*
CHILD BY LEGAL ADOPTION	*Report within 30 days of date of petition or date child takes up residence, whichever is later.*
CHILD BY LEGAL GUARDIANSHIP (WARD)	*Same as legal adoption.*
CHILD FOR WHOM SUBSCRIBER PAYS PRINCIPAL SHARE OF SUPPORT	*Do not confuse with support of stepchildren. Used for relative, such as dependent granddaughter, nephew, etc. Give date support began. The child's effective date will be no earlier than 90 days after support for 6 months has been established.*
OTHER	*Use this area for requesting the addition of any other eligible dependent not mentioned above. Complete the "Additional Information" section as described below.*
ADDITIONAL INFORMATION	*Use this area when adding more than one dependent, also when providing information for an "Other" dependent. Give the name of the event and give last and first name of dependent, social security number and date of occurrence of the event.*
REMOVING MEMBERS (DELETIONS)	
DEATH OF DEPENDENT	*Give name of deceased dependent and date of death.*
DEATH OF INDIVIDUAL (WHO HELD CERTIFICATE)	*See next section, "REQUEST FOR RECORD CHANGE".*
DIVORCED FROM	*Give name of divorced spouse and date of divorce. Under "Additional Information" indicate if coverage for the children is to be continued with the certificate holder or with the certificate to be issued to the divorced spouse.* **ALSO INDICATE SOCIAL SECURITY NUMBER AND ADDRESS OF DIVORCED SPOUSE.**
MARRIAGE OF MINOR OR DEPENDENT	*Give the date of marriage and (new) name of former dependent.* **BE SURE TO ENTER HIS/HER SOCIAL SECURITY NUMBER.** *Under "additional information," give new address of married child, also name and birthyear of spouse.*
REQUEST FOR CHANGES IN RECORD	
CHANGE OF NAME	*Give the new name. Former name should be entered on the top line of the form.*
DEATH OF SUBSCRIBER	*Give the date of death. Under "Additional Information" give name, social security number and address of surviving spouse who is to be offered new certificate. Do not use cancellation area.*
CURRENT BCBSM INFORMATION	*Attach extra sheet with additional names.*
SPECIAL REQUESTS	
EXTRA IDENTIFICATION CARDS	*Request only if original card was lost or damaged or if a Membership or Record Change did not automatically issue due number of cards.*

Back

BCS LIFE INSURANCE COMPANY RESERVES THE RIGHT TO REQUEST PERTINENT SWORN STATEMENTS IF NEEDED.

DO NOT WRITE OR TYPE IN AREA MARKED FOR UNDERWRITER/ADMINISTRATOR USE ONLY.

NAME _____ SOCIAL SECURITY NUMBER _____

FAMILY HEALTH STATEMENT

INSTRUCTION: PLEASE PRINT WITH INK OR USE TYPEWRITER TO ANSWER ALL QUESTIONS ON THIS APPLICATION.

1. CHECK EITHER "YES" OR "NO" TO INDICATE IF THE APPLICANT OR ANY FAMILY MEMBER FOR WHOM THE APPLICANT IS APPLYING FOR COVERAGE HAS BEEN TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING CONDITIONS **WITHIN THE LAST FIVE YEARS.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. ALCOHOLISM OR DRUG ABUSE			10. DIABETES OR HYPOGLYCEMIA			19. MENTAL OR NERVOUS DISEASE/DISORDERS			28. TUMORS		
2. ALLERGIES			11. DIGESTIVE OR STOMACH DISEASE/CONDITIONS			20. NERVOUS OR MUSCLE DISEASE/CONDITIONS			29. FOOT PROBLEMS		
3. BACK OR SPINAL DISEASE/CONDITIONS			12. EAR CONDITIONS			21. PHLEBITIS (CLOTTING IN THE VEIN OF THE LEG)			30. OTHER INJURIES		
4. BIRTH DEFECTS OR DISEASE			13. EPILEPSY OR SEIZURES			22. RESPIRATORY, BREATHING OR LUNG PROBLEMS			31. OTHER DISEASES OR CONDITIONS		
5. BLOOD DISEASE OR CONDITIONS			14. DISEASES, CONDITIONS OR SURGERIES OF THE PELVIC OR REPRODUCTIVE ORGANS			23. DISEASE OF THE SKIN OR NAILS OF LONG DURATION (OVER 3 MOS.)			32. AUTOIMMUNE DISEASE INCLUDING HIV OR AIDS VIRUS		
6. BLOOD PRESSURE PROBLEMS			15. MIGRAINE OR SEVERE, RECURRENT HEADACHES			24. STROKE			33. EYE CONDITIONS		
7. BOWEL OR RECTAL DISORDERS			16. JOINT OR BONE DISEASE OR INJURY			25. SURGICAL OPERATIONS					
8. CANCER			17. KIDNEY, BLADDER OR URINARY DISEASE/PROBLEMS			26. THYROID OR OTHER GLAND-ULAR DISEASE/PROBLEMS					
9. CIRCULATION OR HEART DISEASE/PROBLEMS			18. LIVER DISEASE			27. TUBERCULOSIS					

2. IF ANY OF THE ABOVE BOXES ARE CHECKED "YES", PLEASE EXPLAIN EACH "YES" ANSWER BELOW. ATTACH ADDITIONAL SHEETS IF NECESSARY.

PERSON TO BE COVERED	CONDITION NUMBER	DATE	HOSPITALIZED?	PHYSICIAN (NAME & ADDRESS)	SURGERY PERFORMED?	CONDITION CORRECTED?
		No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

3. **WITHIN THE LAST FIVE YEARS,** HAS THE APPLICANT OR ANY FAMILY MEMBER FOR WHOM THE APPLICANT IS APPLYING FOR COVERAGE BEEN ADVISED BY A PHYSICIAN TO HAVE ANY SURGICAL OPERATION (NOT SPECIFIED ABOVE) OR DIAGNOSTIC TESTS? ☐ YES ☐ NO. IF "YES", GIVE DETAILS BELOW. ATTACH ADDITIONAL SHEETS IF NECESSARY.

PERSON TO BE COVERED	SURGERY OR TEST	PHYSICIAN (NAME & ADDRESS)	DATE	REASON
	☐ SURGERY ☐ TEST			
	☐ SURGERY ☐ TEST			

4. DO YOU OR ANY OF THE FAMILY MEMBERS FOR WHOM YOU ARE APPLYING FOR COVERAGE REGULARLY TAKE MEDICATIONS (PRESCRIPTION OR NON-PRESCRIPTION)? ☐ YES ☐ NO. IF "YES", FOR PRESCRIPTION MEDICATIONS, GIVE DETAILS BELOW. ATTACH ADDITIONAL SHEETS IF NECESSARY.

PERSON TO BE COVERED	NAME OF MEDICATION	PHYSICIAN PRESCRIBING MEDICATION NAME & ADDRESS)

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT SUCH INFORMATION WILL BE USED IN REVIEWING THIS APPLICATION AND THAT MY FAILURE TO PROVIDE COMPLETE AND ACCURATE ANSWERS MAY RESULT IN DENIAL OF CLAIMS, FUTURE MODIFICATION OF MY COVERAGE AND/OR CANCELLATION.

YOUR RIGHT TO CONFIDENTIALITY

WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU EXCEPT: 1) WHEN YOU ASK US IN WRITING, OR 2) WHEN RELEASE (TO ANOTHER INSURANCE COMPANY FOR EXAMPLE) IS NECESSARY TO PROCESS OR REVIEW A CLAIM. WE WILL TELL YOU WHICH INFORMATION WE RELEASED TO WHOM, IF YOU REQUEST IT.

After Completion

_____ _____

SIGNATURE OF APPLICANT DATE

PLEASE RETURN TO:

MDA INSURANCE
3657 Okemos Road, Suite 100
Okemos, MI 48864

APPROVAL OF THIS APPLICATION FOR BCS HEALTH CARE COVERAGE WILL BE INDICATED BY YOUR RECEIPT OF A BILLING NOTICE. **PLEASE DO NOT SUBMIT PAYMENT UNTIL YOU RECEIVE A BILL.**