Application for Blue Cross Blue Shield of Michigan or Blue Care Network of Michigan Individual Coverage

This application may be used for coverage through either Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), depending on which medical plan you choose in Section II below. Dental plans, as set forth in Section III, are only offered through BCBSM, but can be paired with BCBSM or BCN medical plans.

Print in black or blue ink or type your information. **All fields are required to be completed unless otherwise noted.** Review your application for completeness and accuracy and sign and date where requested. The information provided will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website **www.bcbsm.com/index/common/important-information/privacy-practices**.

Health Care Reform Open Enrollment focuses on 2014 products. If you would like to apply for a subsidy or tax credit, a 2013 health plan, or if you are over 30 and wish to apply for a Catastrophic (Value) Plan due to financial hardship, please contact a Health Plan Advisor at 888-899-3012 or your Blues Agent.

To get an individual plan, you need to be a Michigan resident when your coverage starts and you cannot be eligible for Medicare.

Section I: Coverage and Enrollment

What kind of coverage are you applying for? (check all that apply)

☐ Medical Plan
Pediatric vision is included in all medical plans.

☐ Dental Plan
Medical coverage is required to apply for dental coverage. You have the option to apply for separate medical coverage to qualify for dental.

Who will be covered by this plan?

☐ One adult (individual plan) ☐ Multiple people (family plan) ☐ One child only (please skip to "Child Only Information" on page 2)

Why are you applying?

☐ Open Enrollment (October 1, 2013 – March 31, 2014)

☐ I have a qualifying event, loss of coverage, or am planning to move to Michigan.
If you're changing your coverage, you'll need to tell us why and provide documentation. You won't be enrolled in your plan until you do. Some common reasons for coverage changes are the birth of a child, marriage, divorce or loss of employer coverage. Here's how to provide documentation:

- Include the documents with this application, or
- Fax the documents to 877-464-3949 and be sure to include your first and last name and phone number when faxing

Please indicate your qualifying event below:

☐ Loss of coverage through job
☐ Loss of coverage because of reduced work hours
☐ Employer ended health care coverage
Name of insurance company _____ Policy number _____
☐ Moved out of plan coverage area
☐ Birth of child
☐ Adoption of child
☐ Marriage
☐ Divorce
☐ Death of previous policyholder
☐ Loss of COBRA benefits
☐ Turning age 26 or no longer on parent's plan
☐ Other (please give details) _____

Date of above event: _____ (please note that you must apply within 60 days of the event)

Your coverage start date will be assigned after we review your application.

Have you already applied for either a Blue Cross Blue Shield of Michigan or Blue Care Network individual plan to start in 2014?

☐ Yes ☐ No

If yes:

☐ I want BCBSM/BCN to cancel any 2014 application previously submitted
☐ I want to keep all 2014 individual coverage plans

Please tell us about the main person applying for this plan. All of your information will be kept confidential and only used for this application.

Last name	First name	M.I.	Suffix	Social Security Number or Personal Tax ID Number	Are you a U.S. citizen? ☐ Yes ☐ No

Residential address (cannot be a P.O. Box)	City	State	ZIP code	County
Billing address (if different than above)	City	State	ZIP code	County

Email	Primary phone number	Type: ☐ Home ☐ Work ☐ Fax ☐ Cell ☐ Other	Alternate phone number	Type: ☐ Home ☐ Work ☐ Fax ☐ Cell ☐ Other

Gender ☐ Male ☐ Female	Date of birth (if you're under 18, a parent or legal guardian will need to apply for your coverage)	During the past six months, have you been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?* ☐ Yes ☐ No

BCBSM/BCN reserves the right to verify tobacco use and to adjust your premium accordingly. Please see Terms and Conditions for additional information.

Information about your spouse that is applying for this plan

Last name	First name	M.I.	Suffix	Social Security Number or Personal Tax ID Number	Are you a U.S. citizen? ☐ Yes ☐ No

Gender ☐ Male ☐ Female	Date of birth	During the past six months, have you been a regular tobacco user (four or more times per week excluding religious or ceremonial use)?* ☐ Yes ☐ No

BCBSM/BCN reserves the right to verify tobacco use and to adjust your premium accordingly. Please see Terms and Conditions for additional information.

Information about your dependent children (under age 26 on the policy effective date) that are applying for this plan

Last name	First name	M.I.	Suffix	Date of birth	Social Security Number or Personal Tax ID Number (age 1 and older)	Gender	Relationship*	U.S. Citizen?
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No
						☐ Male ☐ Female		☐ Yes ☐ No

During the past six months, has any dependent age 18 and older been a regular tobacco user (four or more times per week excluding religious or ceremonial use)? ☐ Yes ☐ No If yes, who? _____

*Dependent Relationship Codes (we reserve the right to audit documentation for all codes except "N")

N – Child (by birth or adoption) P – Principally supported child A – Child adoption in progress S - Stepchild
C – Court ordered coverage L – Legal guardianship D – Disabled child

Child Only Coverage

Please complete this section if you are a parent or legal guardian applying for coverage for a child who will be under age 21 on the policy effective date. A separate application is necessary for each child requiring Child Only coverage.

Child's last name	Child's first name	M.I.	Suffix	Child's Social Security Number or Personal Tax ID Number (age one and older)	Child's date of birth	☐ Male ☐ Female	U.S. citizen? ☐ Yes ☐ No

Child's residential address	City	State	ZIP code	County
Legal guardian name	Primary phone number	Email		

During the past six months, has this child (age 18 and older) been a regular tobacco user (four or more times per week excluding religious or ceremonial use)? ☐ Yes ☐ No

Section II: Medical Plan Selection (if applying for dental only please skip to Section III)

Here are your plan choices. Your network of affiliated doctors and hospitals may be different based on the product you choose. Please visit bcbsm.com/networks, or consult your coverage documents, health plan advisor or agent for specific network details. The BCN HMO medical plans are managed care products; your care will be coordinated by a primary care physician that you select upon enrollment.

If you're interested in our Healthy Blue Health Savings Account (HSA), just select the HSA option box on any plan that works with an HSA. If you already have our Healthy Blue HSA but pick a non-HSA plan, you can still use the money in your HSA account. But you won't be able to add money to that account once your new plan starts.

There is a $2.95* charge per month for our Healthy Blue HSA. If you would like to learn more please visit **www.bcbsm.com/index/health-insurance-help/faqs/plan-types/health-spending-accounts/healthy-blue-hsa-faq**.

Premiums are charged for the subscriber, spouse, and all adult children age 21 and older and for the three oldest dependent children under age 21. Child Only policies are available on all plans below.

Please select your medical plan from the table below. Medical plans offered through the BCBSM PPO are provided in the column on the left. Medical plans offered through the BCN HMO are provided in the column on the right.

Blue Cross Blue Shield of Michigan PPO Plans	Blue Care Network of Michigan HMO Plans
☐ Blue Cross® Premier **Gold** In-Network deductible: $150 per person; $300 per family Out-of-Network deductible: $300 per person; $600 per family	☐ Blue Cross® Preferred **Gold** In-Network deductible: $250 per person; $500 per family ☐ Blue Cross® Select **Gold** In-Network deductible: $250 per person; $500 per family ☐ Blue Cross® Partnered **Gold** In-Network deductible: $250 per person;$500 per family
☐ Blue Cross® Premier **Silver** In-Network deductible $1,400 per person; $2,800 per family Out-of-Network deductible: $2,800 per person; $5,600 per family ☐ Healthy Blue HSA	☐ Blue Cross® Preferred **Silver** In-Network deductible: $1,650 per person; $3,300 per family ☐ Blue Cross® Select **Silver** In-Network deductible: $1,650 per person; $3,300 per family ☐ Blue Cross® Partnered **Silver** In-Network deductible: $1,650 per person; $3,300 per family
☐ Blue Cross® Premier **Bronze** In-Network inpatient deductible: $4,400 per person; $8,800 per family Out-of-Network inpatient deductible: $8,800 per person; $17,600 per family ☐ Healthy Blue HSA	☐ Blue Cross® Preferred **Bronze** In-Network deductible: $5,950 per person; $11,900 per family ☐ Blue Cross® Select **Bronze** In-Network deductible: $5,950 per person; $11,900 per family ☐ Blue Cross® Partnered **Bronze** In-Network deductible: $5,950 per person; $11,900 per family ☐ Healthy Blue HSA
☐ Blue Cross® Premier **Value** In-Network deductible: $6,350 per person, $12,700 per family Out-of-Network deductible: $12,700 per person, $25,400 per family	☐ Blue Cross® Preferred **Value** In-Network deductible: $6,350 per person, $12,700 per family ☐ Blue Cross® Select **Value** In-Network deductible: $6,350 per person, $12,700 per family ☐ Blue Cross® Partnered **Value** In-Network deductible: $6,350 per person; $12,700 per family

Section III: Dental Plan Selection

Under the health care reform law, every health coverage plan needs to cover 10 essential health benefits. Nine of those benefits are included in the plan you've chosen. The tenth is for pediatric dental care.

To get this benefit, you need to buy a separate qualified dental plan that covers the pediatric dental essential health benefit. All Blue Cross dental plans include this benefit, and you will have the opportunity to select a dental plan after you complete your medical application.

If you don't already have a qualified dental plan that has the pediatric dental benefit, you have three choices:

1. Buy a Blue Dental EPO Personal℠, PPO Personal℠, or PPO Plus Personal℠ dental plan which includes the pediatric dental benefit and covers all members on your contract;
2. Buy a Blue Dental PPO Personal Pediatric℠ plan which includes the pediatric dental benefit. If you select this plan, you will only be charged for children under 19 on your contract and only your children will have dental benefits. If you do not have children under the age of 19, you can still meet the pediatric dental benefit requirement at no additional cost by selecting this plan.
3. Buy qualified dental coverage through another insurance carrier.

Which of the following applies to you? (you must choose one)

☐ I've already bought a qualified dental plan with pediatric dental coverage.
Insurance Company _____ Policy Number _____

☐ I will have purchased a qualified dental plan with the pediatric dental coverage by the date my medical plan coverage starts.

To learn more about Blue Cross dental plans, talk to your Blue Cross agent or call a health plan advisor at 1-877-469-2583.

You must select one of the options below to continue with your medical coverage plan purchase:

☐ Blue Dental PPO Plus Personal℠	Available to all ages; benefits cover all ages
☐ Blue Dental PPO Personal℠	Available to all ages; benefits cover all ages
☐ Blue Dental EPO Personal℠	Available to all ages; benefits cover all ages
☐ Blue Dental PPO Personal Pediatric℠	Available to all ages but the benefits only cover members through the end of the year in which they turn 19. A member cannot be over 18 as of their effective date in order to receive benefits. If the member is over 18 on their effective date, they can select this plan but will not have access to any benefits and will have a $0 rated premium.

Section IV: Additional Information

1. **If applying for a medical plan please answer:**
Is anyone listed on this application eligible for Medicare? ☐ Yes* ☐ No
If yes, who? _____

To be eligible for Medicare under age 65, you need to have one of the following:
- *A disability and be receiving Social Security disability insurance for more than 24 months*
- *A diagnosis of end-stage renal disease*
- *A diagnosis of amyotrophic lateral sclerosis (ALS) as defined by the Center for Medicare and Medicaid Services (CMS)*

*For more information please visit our Medicare page at **www.bcbsm.com/plans/medicare.***

*** If you're eligible for Medicare, you can't apply for individual medical coverage. Please visit our Medicare page to learn more.**

2. **If applying for a medical plan please answer:**
Is anyone listed on this application eligible for Medicaid? ☐ Yes ☐ No
If yes, who? _____

*To be eligible for Medicaid, you need to be a Michigan resident and meet the financial criteria of the State of Michigan and the Federal Government. For more information, please visit our Medicaid page at **www.mibluecrosscomplete.com/member/blue-cross-complete/blue-cross-complete-of-michigan***

3. **If applying for a medical plan please answer:**
Will you have more than one medical health plan on the effective date of this policy? ☐ Yes ☐ No
If yes, is this coverage individual or group?
What is the name of the insurance company providing this coverage? _____

4. **If applying for a dental plan please answer:**
Are you or any family members applying for medical coverage or currently active under a medical plan? ☐ Yes ☐ No
If yes, name of insurance company: _____
Contract number: _____ Group number: _____

Section V: Optional Information

The following questions are completely optional, but your responses will help us to develop programs, products and networks that meet our member's needs. Your responses will not impact your health care plan options or costs in any way.

1. Please pick a primary care physician (PCP) for each family member on your plan**. If you've selected an HMO plan and don't choose a PCP, we will pick one for you and your family members.**

If you don't know your physician's National Provider Identification (NPI) or other information, you can use our provider directory at **www.bcbsm.com/index/common/find-a-doctor.** To see the nearest pharmacies in your network please use our pharmacy directory at **www.bcbsm.com/medicare/rxdirectory.**

*fee is subject to change

	Physician's First Name	Physician's Last Name	Physician's NPI	Seen in last year?
Applicant				☐Yes ☐No
Spouse				☐Yes ☐No
Child				☐Yes ☐No
Child				☐Yes ☐No
Child				☐Yes ☐No
Child				☐Yes ☐No

2. Have you or any family members applying for coverage been diagnosed with or treated for any of these medical conditions? (do not provide information for any family members who will not be covered under this contract)

☐ Yes ☐ No If yes, please check all that apply and list the family member with the condition(s):

√	Medical condition	Name of family member(s) with the condition
	Cancer	
	COPD/Asthma	
	Diabetes	
	Mental Health Disorder	
	Heart Disorder	

3. My yearly household income is:

☐ Less than $30,000 ☐ $30,000 to $45,000 ☐ $45,000 to $70,000 ☐ $70,000 to $90,000 ☐ Greater than $90,000

4. Race (check all that apply for all family members)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

If Hispanic/Latino, ethnicity (check all that applies for all family members):

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

Section VI: Payment Options

Your security and privacy are important to us. We keep all your personal, medical and financial information confidential and safe using industry-standard certifications and information privacy practices. You can view our privacy statement at **www.bcbsm.com/index/common/important-information/privacy-practices**.

Please tell us how you'll be paying for your first monthly premium and future payments. Once you submit this application, you'll be enrolled in your plan. Don't worry; all of your payment information will be kept secure.

1. Who will pay the premium for this policy?

☐ Self ☐ Legal guardian ☐ Employer ☐ Family member ☐ Health Care Provider ☐ Other (please specify) _____

2. How do you want to pay your initial premium?

☐ Electronic Fund Transfer (EFT); please complete section below
If you chose this option, your first monthly payment will be debited from your account 2 to 3 days after your application is approved. You'll receive an email confirmation once your application is approved. Note: all future payments will be debited on the 25th of each month.
☐ Credit Card (please complete last page of this application)
☐ Bill Me

3. How do you want to make ongoing payments?

☐ Electronic Fund Transfer (EFT); please complete the section below
☐ Bill Me

Electronic Fund Transfer (EFT) automatically deducts your premium payments from an account you designate.			
Full Name (First, Middle, Last)			
Residential Address	E-Mail Address		
City	State	Zip Code	Primary Phone Number
Name of Financial Institution	Type of Account ☐ Checking ☐ Savings		
Bank Account Number	ABA/Routing Number (9 digits)		

Automatic payment cannot be processed without your signature. I authorize Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network (BCN) to deduct payments from the bank account listed above. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify BCBSM or BCN by calling BCBSM at 1-888-288-2738 or BCN at 1-800-662-6667, or by accessing my information at **www.bcbsm.com**. I understand that I must contact BCBSM or BCN to discontinue automatic payments at least 2 days prior to the premium due date. I understand that all information provided will remain confidential.

Signature _____ Date _____

Section VII: Consent, Terms and Conditions

BLUE CROSS BLUE SHIELD OF MICHIGAN OR BLUE CARE NETWORK OF MICHIGAN PLANS

I understand that I am eligible for this coverage if I am a resident of Michigan on the effective date of the policy, and that I am not eligible for or enrolled in Medicare. I certify that I am a U.S. citizen or a Legal Alien.

If I am applying for coverage outside of the open enrollment period, I certify that I meet one of the qualifying events as defined by the Affordable Care Act (ACA).

I am applying for health coverage through Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), based on the specific plan(s) I selected, and understand that I will be subject to the terms and conditions of this application, and I agree that I will also be bound by all provisions in the applicable plan certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable. Additional information may be required of me. Coverage is contingent on timely payment of premium.

I certify that the requirements of eligibility are met and that all of the information supplied on this application is true, correct, and complete to the best of my knowledge. I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation and/or false or misleading information may result in termination or rescission of coverage. BCBSM or BCN, as applicable, has the right to test for tobacco usage in order to determine applicable rates, and that BCBSM or BCN, as applicable, can retroactively adjust premium rates back to the effective date based on results of tobacco (cotinine) testing. Regular tobacco use is defined as four or more times per week excluding religious or ceremonial use.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

This coverage is not an employer group health plan and is not intended in any way to be an employer-sponsored health insurance plan. I certify that my or my spouse's employer will not contribute any part of the premium, nor will I or my spouse be reimbursed for any part of the premium by the employer now, or in the future.

I may enroll my legal spouse and eligible dependents. Eligible dependents are defined as children of mine or my spouse by birth, legal adoption, or legal guardianship. Eligible dependents must be 25 years of age or younger on the policy effective date. I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own individual coverage.

With regard to costs of hospital and medical services delivered by or paid for by BCBSM or BCN, as applicable, I agree to assign my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under Worker's Compensation laws or acts whether by redemption award or voluntary payment or otherwise to BCBSM or BCN, as applicable.

HEALTHY BLUE HSA (HEALTH SAVINGS ACCOUNT)

The Healthy Blue HSA is available to customers enrolled in Blue Cross Premier Silver or Bronze PPO plans, or the Blue Cross Preferred, Select, or Partnered Bronze HMO plans. The Healthy Blue HSA is powered by HealthEquity®. HealthEquity® is an independent company partnering with Blue Cross Blue Shield of Michigan and Blue Care Network to provide health care spending account administration services. An independent and FDIC-insured bank holds the health savings account dollars.

Healthy Blue HSA accounts will be charged a $2.95* per month per funded account administrative fee. The fee will be deducted from your account balance. If you do not have an account balance, you will not be charged the monthly fee.

Silver plan holders receiving cost-sharing subsidies obtained through the Health Insurance Marketplace, as well as those receiving Native American cost-sharing subsides on a Silver or Bronze plan cannot open a Healthy Blue HSA. If you have already established a Healthy Blue HSA and begin to receive these cost-sharing subsidies, or if you switch to a non-HSA eligible plan with Blue Cross or another insurer, you will continue to own the funds in the plan and may continue to spend from your HSA but you will no longer be able to contribute to and manage your HSA through your account at bcbsm.com. Blue Cross will notify HealthEquity® of your ineligibility and you will receive information on how to continue managing your account within one month of the date of ineligibility.

CATASTROPHIC (VALUE) PLANS

Catastrophic plans including Blue Cross Premier Value PPO, Blue Cross Preferred Value HMO, Blue Cross Select Value HMO, and Blue Cross Partnered Value HMO are available to those under the age of 30 or those that have received a certification of exemption from the individual mandate due to affordability or hardship from the Health Insurance Marketplace. All members on the plan, including spouses and dependents, must be under the age of 30 as of the effective date of the plan to be eligible to enroll in a Catastrophic plan. If you meet this eligibility requirement, you can stay in a Catastrophic plan for the duration of the calendar year.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that information collected about me as provided by this authorization will be used for the purposes noted below as well as to determine my eligibility for health coverage. BCBSM or BCN may collect personal and protected health information (PHI) about me in order to process my application for coverage. BCBSM or BCN will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on **bcbsm.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on BCBSM's and/or its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN.

My authorization includes disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This PHI is to be disclosed so that BCBSM or BCN may: (1) perform case, care and disease management, (2) validate rating factors allowable under the Patient Protection and Affordable Care Act (PPACA), (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (4) for other legally permissible purposes, including but not limited to, healthcare operations. If BCBSM re-discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information and if I provide this authorization, information may be re-disclosed by the recipient and no longer protected. I understand and acknowledge that if I am applying for coverage from BCN that this restriction on re-disclosure does not apply, but if BCN does re-disclose my information it may no longer be protected.

*fee is subject to change

I understand that my enrollment with BCBSM or BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM or BCN and its subsidiaries and from any of the parties listed above to BCBSM or BCN. A copy or other reproduction of this authorization shall be valid as the original.

My authorization expires upon the later of (i) rescission or rejection of coverage by BCBSM or BCN; or (ii) I cause my coverage to terminate or it otherwise expires. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **www.bcbsm.com** or by contacting my agent. I understand that revocation will not affect actions taken before BCBSM or BCN or any of the parties identified above receive my request.

Section VII: Sign and Date

Please review your application for completeness and accuracy, and sign and date below. A dated signature is required for each applicant age 16 and older.

I understand that a Summary of Benefits and Coverage (SBC) related to the coverage for which I am applying is available on the web at: **www.bcbsm.com/SBC**. I understand the SBC is not a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the SBC and my applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the SBC electronically via the website. I understand a paper copy is also available, free of charge, by calling BCBSM at 1-888-288-2738 or BCN at 1-800-662-6667, as applicable (both numbers are toll free).

Signature of Applicant (if child only policy, legal guardian must sign)	Date
Signature of Spouse	Date
Signature of Dependent (age 16 or older)	Date
Signature of Dependent (age 16 or older)	Date

Mail your completed application to:

Action Benefits - Individual Processing Team
26533 Evergreen Rd., Suite 400
Southfield, MI 48076

Area Below for Agent Use Only

Agent first name	Agent last name	Agency name	Agent ID number	
Louis	Isabell	Allchoice, Inc.	09826 NPN 1340419	
Phone number	Address	City	State	ZIP code
(248) 349-5370	28004 Center Oaks Ct. Ste. 205	Wixom	MI	48393
MA/GA name		Association/Chamber		
03 Action Benefits				
Agent signature			Date signed	

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Credit Card Payment (for initial premium payment only)

Note: If you are submitting your application through an agent or by U.S. Mail and do not want your first premium payment paid by credit card, please remove this page before submitting the application.

This option offers the convenience of making your first premium payment by credit card. Your coverage is assigned an effective date upon approval, but is not active until payment is received by BCBSM or BCN as applicable. Using a credit card to pay your premium will activate your coverage more quickly. Your Identification Card is issued immediately, but coverage will not be activated until payment is received. Credit card payment can be used for your initial premium payment only.

Credit Card
☐ Visa ☐ MasterCard

Cardholder's Name (exactly as it appears on the card)			Social Security Number
Credit Card Number		Card Expiration Date	Card Verification Code
Cardholder Billing Address			
Street Address		City	
State	ZIP code	Daytime phone number	

Credit card payment cannot be processed without your signature. I authorize BCBSM or BCN as applicable to charge my credit card for my health care premium payment amount. I understand that all information provided will remain confidential.

_____ _____

Signature **Date**