

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: 800-869-BLUE (2583)

Automatic Payment Plan for Individual and Direct Billed Customers

BCBSM Automatic Payment Plan offers the convenience of paying your health care bill on time, every time. No need to write checks, mail payments or worry about late payments resulting in rejected services. To participate, simply fill out and mail in this enrollment form. Please include a blank, voided check or a deposit slip from your designated account for verification. Please allow three to four weeks for processing your application. Continue to mail your payment as usual until you see "Automatic Payment" on your bill.

Enrollment is easy. Just complete this enrollment form and mail it along with your application.

Please complete the requested information below: (Please print or type)

Last NameFirst NameMiddle Initial

Address

CityStateZip Code

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Daytime Phone Number

Please include a blank, voided check or deposit slip from your designated account

Name of Financial Institution _____

Please check one: Checking Account Savings Account

Bank Account NumberABA/Routing Number (9 digits)

This form cannot be processed without your signature

I authorize Blue Cross Blue Shield of Michigan to deduct my payments from the checking or savings 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. I also understand that all information provided will remain confidential.

SignatureDate

BCBSM Use Only

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