

# Application For Enrollment

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)

EMPLOYEE NAME (LAST) (FIRST) (MI)

\_\_\_\_\_

STREET ADDRESS

\_\_\_\_\_

CITY ST ZIP

\_\_\_\_\_ - \_\_\_\_\_

<p>FILL IN ONE:</p> <p><input type="radio"/> Dr.    <input type="radio"/> Ms.</p> <p><input type="radio"/> Mr.    <input type="radio"/> Miss</p> <p><input type="radio"/> Mrs.</p>	<p>FILL IN ONE:</p> <p><input type="radio"/> MALE</p> <p><input type="radio"/> FEMALE</p>	<p>FILL IN ONE:</p> <p><input type="radio"/> SINGLE    <input type="radio"/> DIVORCED</p> <p><input type="radio"/> MARRIED    <input type="radio"/> WIDOWED</p>
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EMPLOYEE NO.

\_\_\_\_\_

GROUP NO. DIV NO.

\_\_\_\_\_

PHONE NUMBER

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYEE'S SOCIAL SECURITY NO.

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

EMPLOYEE'S DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

ARE YOU AN EXISTING COBRA PARTICIPANT?

- Yes
- No, skip to Type of Medical Coverage Selected

TYPE OF MEDICAL COVERAGE SELECTED

- INDIVIDUAL     FAMILY     OTHER

WHEN DID YOUR COBRA COVERAGE BEGIN?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

WHEN DOES YOUR COBRA COVERAGE END?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

TYPE OF DENTAL COVERAGE SELECTED (if available)

- INDIVIDUAL     FAMILY     OTHER

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

1. LAST NAME SOCIAL SECURITY NUMBER

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

FIRST NAME MI RELATIONSHIP DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Husband     Wife

2. LAST NAME SOCIAL SECURITY NUMBER

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

FIRST NAME MI RELATIONSHIP DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Son     Daughter

3. LAST NAME SOCIAL SECURITY NUMBER

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

FIRST NAME MI RELATIONSHIP DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Son     Daughter

4. LAST NAME SOCIAL SECURITY NUMBER

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

FIRST NAME MI RELATIONSHIP DATE OF BIRTH (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Son     Daughter

LAST NAME NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS

\_\_\_\_\_

Part A

PART "A" EFFECTIVE DATE (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

FIRST NAME MEDICARE NUMBER

\_\_\_\_\_

Part B

PART "B" EFFECTIVE DATE (MM/DD/YYYY)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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**NATURE OF APPLICATION**

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="radio"/> NEW CONTRACT APPLICATION | <input type="radio"/> CANCEL CONTRACT<br><input type="radio"/> Medical Coverage<br><input type="radio"/> Dental Coverage<br><input type="radio"/> Medical and Dental Coverage | <input type="radio"/> CHANGE CONTRACT<br><input type="radio"/> Name Change<br><input type="radio"/> Address Change<br><input type="radio"/> Type of Coverage Change<br><input type="radio"/> Change COB Information<br>(MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="radio"/> ADD DEPENDENT<br><input type="radio"/> Add Spouse<br><input type="radio"/> Add Dependent Child | <input type="radio"/> REMOVE DEPENDENT<br><input type="radio"/> Marriage of Child under 19<br><input type="radio"/> Entered Military Service<br><input type="radio"/> Divorce<br><input type="radio"/> Death<br><input type="radio"/> Remove Spouse<br><input type="radio"/> Remove Child |
|--|---|--|--|---|

DATE EVENT OCCURRED (Example: Date of marriage, birthdate of child, etc.)

**COORDINATION OF BENEFITS INFORMATION** - If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information:

NAME OF CONTRACT HOLDER/DEPENDENT	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE COVERAGE <input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY	NAME OF INSURANCE COMPANY
EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)	EMPLOYER'S NAME	CITY	STREET ADDRESS
	GROUP NUMBER		CITY, STATE, ZIP

**STUDENT EXTENSION CERTIFICATION** - List any dependent child applying for student extension

NAME OF CHILD _____	NAME OF SCHOOL _____
NAME OF CHILD _____	NAME OF SCHOOL _____

**CURRENT BLUE CROSS COVERAGE** - If you or your spouse are currently covered by a Blue Cross and Blue Shield contract and wish to transfer to this group, please complete below:

CURRENT BLUE CROSS AND BLUE SHIELD CONTRACT NUMBER \_\_\_\_\_

CITY AND STATE OF BLUE CROSS PLAN ENROLLED \_\_\_\_\_

- I waive my right to benefits and do not wish to enroll.
- I am requesting cancellation of my existing benefits as checked above.
- I apply for the Group Health Benefits

Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this

application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is to return any fees I paid. You may pay providers directly for services to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed

or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, I am a late enrollee and will be required to serve an 18 month exclusion period (unless otherwise stated by your plan) for pre-existing conditions.

PRINT NAME	SOCIAL SECURITY NUMBER
SIGNATURE OF EMPLOYEE	DATE SIGNED (MM/DD/YYYY)
SIGNATURE AND TITLE OF EMPLOYER	DATE EMPLOYED (MM/DD/YYYY)
EMPLOYER'S NAME	EMPLOYER PHONE NUMBER
EMPLOYER'S ADDRESS	