BlueCross BlueShield of Alabama

Application For Enrollment

Fields marked with an * are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

☐ DR. ☐ MR. ☐ MRS. ☐ MS. ☐ REV.

HEALTH GROUP NUMBER

HEALTH DIVISION NUMBER

*HEALTH PLAN SELECTED ☐ PREMIUM ☐ CORE ☐ HEALTH SAVINGS

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER – –

*HOME MAILING ADDRESS

*CITY

*STATE

*ZIP

*PRIMARY TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL ( ) – –

ALTERNATE TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL ( ) – –

E-MAIL ADDRESS (Optional)

*GENDER ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

EMPLOYEE NUMBER

MARITAL STATUS (MARK ONE) ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*TYPE OF HEALTH COVERAGE SELECTED ☐ INDIVIDUAL ☐ FAMILY ☐ OTHER

*TYPE OF DENTAL COVERAGE SELECTED ☐ INDIVIDUAL ☐ FAMILY ☐ OTHER

DEPENDENT INFORMATION

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

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER – –

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER

GENDER (Check One) ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

DEPENDENT

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER – –

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER

GENDER (Check One) ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

DEPENDENT

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER – –

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER

GENDER (Check One) ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

DEPENDENT

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER – –

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER

GENDER (Check One) ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

DEPENDENT

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
		___ – ___ – ____

*RELATIONSHIP	GENDER (Check One)	*DATE OF BIRTH (MM/DD/YYYY)
☐ SPOUSE ☐ CHILD ☐ OTHER	☐ MALE ☐ FEMALE	___ / ___ / ____

If any dependent child above is over the applicable maximum age under your Group Plan (age 26) and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

NATURE OF APPLICATION*

☐ NEW CONTRACT	☐ CANCEL CONTRACT	☐ CHANGE CONTRACT	☐ ADD DEPENDENT ☐ Spouse ☐ Child
		☐ Name Change ☐ Address Change ☐ Type of Coverage Change	☐ REMOVE DEPENDENT ☐ Spouse ☐ Child REASON FOR REMOVAL ☐ Entry Into Military Service ☐ Divorce ☐ Death ☐ Request

ENROLLMENT EVENT TYPE

☐ Regular Enrollment ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage
☐ Other _____

DATE EVENT OCCURRED (MM/DD/YYYY)
___ / ___ / ____

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health and/or dental plan or policy at the time this policy becomes effective? If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)	
	___ / ___ / ____	
NAME OF INSURANCE COMPANY	**EMPLOYER'S NAME**	
POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	**GROUP NUMBER**	**TYPE COVERAGE**
		☐ INDIVIDUAL ☐ FAMILY

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete the information below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER	

MEDICARE BENEFITS INFORMATION

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	MEDICARE NUMBER

PART A	EFFECTIVE DATE (MM/DD/YYYY)	PART B	EFFECTIVE DATE (MM/DD/YYYY)	PART D	EFFECTIVE DATE (MM/DD/YYYY)
◯	___ / ___ / ____	◯	___ / ___ / ____	◯	___ / ___ / ____

TO BE COMPLETED BY EMPLOYEE

☐ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

☐ 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 directly 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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records 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 and/or dental 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.

LAST NAME	FIRST NAME

MAIDEN/MIDDLE NAME	**SUFFIX** (JUNIOR, SENIOR)	SOCIAL SECURITY NUMBER
		___ – ___ – ____

*SIGNATURE OF EMPLOYEE

_____

DATE SIGNED (MM/DD/YYYY)	**FULL-TIME EMPLOYMENT DATE** (MM/DD/YYYY)
__ / __ / ____	__ / __ / ____

TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME	*GROUP NUMBER

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
	(___)– ___ – ____

PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION
_____	X ____

*GROUP ADMINISTRATOR'S SIGNATURE	**DATE SIGNED** (MM/DD/YYYY)
_____	__ / __ / ____

IMPORTANT DISCLOSURE NOTICE

NOTICE OF GROUP HEALTH PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.