BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Application For Enrollment

SEE BACK FOR IMPORTANT INFORMATION

PLEASE PRINT: (USE BLACK BALL POINT PEN — PRESS FIRMLY)

EMPLOYEE NAME (LAST)	(FIRST)	(MI)	EMPLOYEE'S DATE OF BIRTH

STREET ADDRESS	CITY	ST	ZIP

EMPLOYEE'S SOCIAL SECURITY NO.	FILL IN ONE:	FILL IN ONE:	FILL IN ONE:	GROUP NO.	DIV NO.
	○ MALE ○ FEMALE	○ SINGLE ○ DIVORCED ○ MARRIED ○ WIDOWED	○ DR. ○ MS. ○ MISS ○ MR. ○ MRS.		

ARE YOU AN EXISTING COBRA PARTICIPANT?	WHEN DID YOUR COBRA COVERAGE BEGIN?	WHEN DOES YOUR COBRA COVERAGE END?
○ Yes ○ No, skip to Type of Medical Coverage Selected		

TYPE OF MEDICAL COVERAGE SELECTED	TYPE OF DENTAL COVERAGE SELECTED (if available)	EMPLOYEE NO.	PHONE NUMBER
○ INDIVIDUAL ○ FAMILY	○ INDIVIDUAL ○ FAMILY		

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.

	LAST NAME	FIRST NAME	MI	RELATION -SHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MM DD YYYY
1.				○ Husband ○ Wife		
2.				○ Son ○ Daughter		
3.				○ Son ○ Daughter		
4.				○ Son ○ Daughter		

STUDENT EXTENSION CERTIFICATION — List any dependent child applying for student extension

NAME OF CHILD _____ NAME OF SCHOOL _____

NAME OF CHILD _____ NAME OF SCHOOL _____

NATURE OF APPLICATION

○ NEW CONTRACT APPLICATION

CANCEL CONTRACT
○ Medical Coverage
○ Dental Coverage
○ Medical and Dental Coverage

CHANGE CONTRACT
○ Name Change
○ Address Change
○ Type of Coverage Change
○ Change COB Information

ADD DEPENDENT
○ Add Spouse
○ Add Dependent Child

REMOVE DEPENDENT
○ Marriage of Child under 19
○ Entered Military Service
○ Divorce
○ Death
○ Remove Spouse

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	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE COVERAGE ○ INDIVIDUAL ○ FAMILY	NAME OF INSURANCE COMPANY

EMPLOYER'S	CITY	GROUP NUMBER	STREET ADDRESS

NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS ○ Part A ○ Part B	MEDICARE NUMBER	CITY, STATE, ZIP

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 rights 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 waiting period (unless otherwise stated by your plan) for pre-existing conditions.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____ DATE EMPLOYED _____

SIGNATURE OF EMPLOYER (Employer's Verification of Applicant's Employment) _____ DATE SIGNED _____ ( ) - EMPLOYER PHONE NUMBER

EMPLOYER'S NAME	EMPLOYER'S ADDRESS