Blue Cross Blue Shield Membership Application

1. Please indicate reason for Application: ☐ **New Member(s)** ☐ **Coverage Change** ☐ **Cancel** ☐ **Miscellaneous**
☐ COBRA: ☐ 18-Mo. ☐ 29-Mo. ☐ 36-Mo. (Block **17** must be completed) ☐ Transfer Within Your Group From _____
☐ Left Employment: ☐ Wants Conversion or Medical Complementary Info ☐ Deceased ☐ Name Change
☐ Department / Payroll Number Change ☐ Address Change ☐ Social Security Number Change From _____
☐ ID Card Request ☐ Add Dependents ☐ Return From Layoff/Medical Leave ☐ Other _____

2. EFFECTIVE DATE OF ACTION REQUESTED: Month ____ Day_____ Year_____
DATE OF HIRE: Month____ Day _____ Year _____
ELIGIBILITY DATE: Month ____ Day ____ Year_____

3. Type of Contract: ☐ PPO

IDENTIFICATION

4. Employee – Last Name | First | Initial | Home Telephone No.

5. Social Security No.

6. Mailing Address (Street or P.O. Box) | (City) | (State) | (Zip Code) | (County Code)

7. Name of Employer

8. Blue Cross Group Number ☐☐-☐☐☐☐☐-☐☐-☐

9. Dept No.

10. Payroll No.

REASON FOR COVERAGE CHANGE

11. Check appropriate reason; give occurrence date in Block 13:
A ☐ Birth or Adoption
B ☐ Death (Name:_____)
C ☐ Divorce
D ☐ Marriage
E ☐ Other – Explain: _____

12. Name of spouse to be excluded from coverage if applicable _____

13. Occurrence Date or Left Employment Date
Mo. Day Yr. _____

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired. (Indicate life coverage desired, if applicable, in blocks 15 through 19.)

	a. HEALTH	**b. DENTAL**
S – Single	☐	☐
F – Family	☐	☐
F – Employee/Children	☐	☐
8 – Employee/Spouse	☐	☐

c. REFUSAL OF HEALTH COVERAGE
01 ☐ Other Insurance with BCBS
02 ☐ Insurance with another company
03 ☐ US military coverage
04 ☐ Federally qualified HMO
07 ☐ My spouse's coverage with this group
09 ☐ Other third-party administrator
11 ☐ Non-federally qualified HMO
12 ☐ Covered by Medicare
13 ☐ Covered by CHAMPUS
05 ☐ Other – Explain:_____

15. If Sponsored Membership, give Sponsor's Social Security No. _____

16. List All Family Members Covered or Affected By a Change

Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.	Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.
YOURSELF:									
Spouse					Child				
Social Security No.					Social Security No.				
Child					Child				
Social Security No.					Social Security No.				
Child					Child				
Social Security No.					Social Security No.				
Child					Child				
Social Security No.					Social Security No.				

OTHER INSURANCE INFORMATION

17. Do you or does any member of your family have other health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? ☐ YES ☐ NO
If Yes: MEDICARE A ☐ Effective Date _____ MEDICARE B ☐ Effective Date_____
A. Family Member's Name _____ and Social Security Number _____
B. Name of Insurance Co._____ Policy No._____ Effective Date _____
C. Family Member's Employer _____
D. List Names of Covered Persons 1. _____ 2._____ 3. _____ 4._____
E. **Please circle each type of service covered by this policy: Hospital, Physician / Medical, Prescription Drugs, Dental, Vision**

EMPLOYEE CERTIFICATION

18. Employee Certification **I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.**
Date: _____ Signature:_____