Carolina ADVANTAGE

# Enrollment Application and Change Form

## Important Instructions

Coverage does not become effective under any circumstances until an application has been approved by BlueChoice HealthPlan.

- Please print in ink or type.
- The application must be completed in full and signed where indicated.
- Completed application must be received by BlueChoice HealthPlan's Membership Department within 30 days from the signature date and sent to BlueChoice HealthPlan, Membership Department, AX-425, P.O. Box 6170, Columbia, S.C. 29260-6170.

## INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).

B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.

C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.

D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.

E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.

BlueChoice® HealthPlan
South Carolina

BlueChoice® HealthPlan
South Carolina

# ENROLLMENT APPLICATION AND CHANGE FORM

| New Enrollment ☐<br>Effective Date: _____ | Change ☐<br>Effective Date: _____ | **INTERNAL USE ONLY**<br>Pre-X Date: _____ |
|---|---|---|

## A. IF MAKING A CHANGE

ENROLLMENT CHANGE DATE DUE TO:

☐ Marriage ☐ Birth/Adoption ☐ Termination ☐ COBRA Applicant – Start Date: _____ End Date: _____

☐ Death ☐ Address Change ☐ Other: _____

## B. TO BE COMPLETED BY ALL EMPLOYEES

1. Employee Actively At Work ☐ COBRA ☐ Retired ☐

| 2. Social Security No. | 3. Employee – Last Name First | Date of Birth MM DD CCYY | Sex: Male ☐ Female ☐ |
|---|---|---|---|
| ___ - ___ - ____ | | ___ - ___ - ____ | |

4. Mailing Address Street or P.O. Box City State ZIP Code

| 5. Home Phone | Work Phone | 6. E-Mail Address: |
|---|---|---|
| ___ - ___ - ____ | ___ - ___ - ____ | |

| 7. Name of Employer: | 8. Full-time Date of Hire: |
|---|---|

| Job Title or Description: | BlueChoice HealthPlan Group Number: | Dept. No.: | Payroll No.: |
|---|---|---|---|

## C. MEMBERSHIP AND COVERAGE INFORMATION

Check for Type of Contract: ☐ Standard ☐ HDHP

| | Medical | Comprehensive Dental |
|---|---|---|
| S – Single | ☐ | ☐ |
| F – Employee/Spouse/Children | ☐ | ☐ |
| D – Employee/Children | ☐ | ☐ |
| 8 – Employee/Spouse | ☐ | ☐ |
| 0 – No Benefits | ☐ | ☐ |

**Reason for Waived Coverage:**

☐ Insurance with another company

☐ Covered by spouse with this employer

☐ Other - Explain: _____

## D. COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

List All Family Members To Be Covered or Affected By A Change. Do Not Use Nicknames.

| | Last Name First | Sex | Date of Birth Mo. Day Yr. | Social Security No. | Height | Weight |
|---|---|---|---|---|---|---|
| Yourself | | | | ___ - ___ - ____ | | |
| Spouse | | | | ___ - ___ - ____ | | |
| Child | | | | ___ - ___ - ____ | | |
| Child | | | | ___ - ___ - ____ | | |
| Child | | | | ___ - ___ - ____ | | |
| Child | | | | ___ - ___ - ____ | | |

**Life and/or Disability coverage is provided by Companion Life Insurance Company**

**Companion Life is a separate life insurance company that does not provide BlueChoice HealthPlan products or services. Companion Life is solely responsible.**

| Types and Amounts of Coverage Requested: | Earnings: | (Check One) | Life Class |
|---|---|---|---|
| ☐ Life $_____<br>☐ AD & D $_____<br>☐ Dep. Life $_____<br>☐ STD $_____<br>☐ LTD $_____ | $_____<br>(Amount) | ☐ Hourly<br>☐ Weekly<br>☐ Biweekly<br>☐ Monthly<br>☐ Annually | |

List Primary Beneficiary(ies) (Last Name, First, Middle Initial) Relationship

Primary Beneficiary(ies): _____

Contingent Beneficiary: _____

☐ **Life Only (Life insurance coverage is provided by Companion Life Insurance Company)**

## E. OTHER INSURANCE INFORMATION

Are you or any dependents to be covered by this policy enrolled in Medicare? ☐ Yes ☐ No HIC # or Policy #:_____

If yes: ☐ Medicare A - Effective Date:____/____/_____ ☐ Medicare B - Effective Date:____/____/_____

Name of Person(s):_____ Name of Person(s):_____

Does anyone being covered by this policy have any other Health, Dental or Drug coverage? ☐ Yes ☐ No If Yes, complete this section.

Policyholder's Name:_____ ID Card Number: _____

Name of Insurance Co.:_____ Policy No.:_____ Effective Date: ____/____/_____

Policyholder's Employer: _____

List All Persons Covered: 1._____ 2. _____ 3. _____

Indicate type of services covered by this policy: ☐ Hospital ☐ Physician/Medical ☐ Prescription Drugs ☐ Dental

## F. HEALTH INFORMATION TO BE COMPLETED BY ALL EMPLOYEES

Please complete the following questions for you or any dependents to be covered:

a. In the last 12 months has any person had in excess of $2,500 medical expenses? ☐ Yes ☐ No

b. In the last three years has anyone been denied insurance for health reasons or been issued an exclusion rider? ☐ Yes ☐ No

c. Are you or your spouse now pregnant? If yes, provide expected delivery date:_____. ☐ Yes ☐ No

d. Is there a history of infertility, complicated pregnancy, multiple births, premature birth or sick newborn? ☐ Yes ☐ No

e. Is any person currently disabled or not actively at work? ☐ Yes ☐ No

f. Has any individual to be enrolled taken prescription drugs in the last 12 months? ☐ Yes ☐ No

g. Within the last 10 years has any person been hospitalized, had surgery, consulted or been treated by a physician for an injury or illness other than flu, colds, sore throat or routine checkups? ☐ Yes ☐ No

h. Has any person used any form of tobacco or nicotine substitute in the last 12 months? ☐ Yes ☐ No

**If you answered yes to any of the above questions, please provide the dates and details below in the next section.**

**SEPARATE PERSONAL HEALTH STATEMENTS MUST ALSO BE COMPLETED FOR GROUPS WITH 2-19 ELIGIBLE EMPLOYEES.**

## G. HEALTH INFORMATION DETAILS

| Patient's Name | Doctor's Name, Address & Phone # | Condition | Dates | Treatment/Medication | Results/Prognosis |
|---|---|---|---|---|---|
| | | | / / | | |
| | | | / / | | |
| | | | / / | | |
| | | | / / | | |
| | | | / / | | |
| | | | / / | | |
| | | | / / | | |

### AUTHORIZATION TO RELEASE INFORMATION AND STATEMENT OF UNDERSTANDING

I hereby authorize the release of any medical or non-medical information about me or my eligible or enrolled dependents by any insurance company, medical professional, medical institution or other health care provider concerning the diagnosis, treatment and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand that the benefits for which I (we) will be eligible are those disclosed in the group contract between BlueChoice HealthPlan and my employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations have been made on this application subject to the Time Limit on Certain Defenses or Incontestability Provision. All statements made herein are complete and true to the best of my knowledge.

I HAVE READ AND FULLY UNDERSTAND EACH AND EVERY PART OF THIS APPLICATION FOR INSURANCE.

Applicant's Signature:_____ Date:_____

## GENERAL NOTICE OF PRE-EXISTING CONDITION LIMITATION
## APPLIES TO BLUECHOICE HEALTHPLAN MEDICAL BENEFITS ONLY

This plan may contain a pre-existing condition exclusion. This means that if you have a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date, you might have to wait a certain period of time before that plan will provide coverage for that condition. This six-month period ends the earlier of the day before your coverage becomes effective (the effective date) or if you were in a waiting period for coverage, the day before the waiting period begins (the enrollment date). The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

BlueChoice HealthPlan
Member Services Department
Post Office Box 6170
Columbia, SC 29260-6170
or call
1-866-858-3272
or 803-382-5309 in Columbia

## DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

BlueChoice® HealthPlan
South Carolina

HEALTH PLAN NCQA ACCREDITATION EXCELLENT