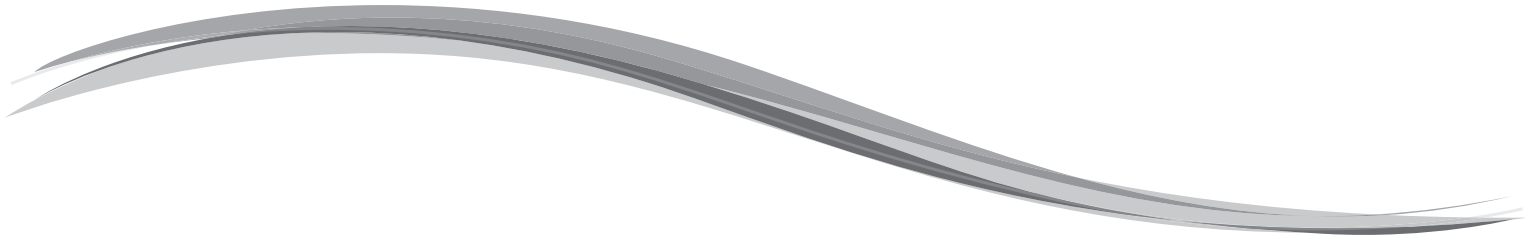
Enrollment Application/Change Form



Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

603316.1215

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all Sections where applicable.

Add Dependent: Complete all Sections where applicable.

- If you are adding or enrolling a dependent due to adoption or placement for adoption, you must provide legal documents.
- If you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree.
- If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.

Completion of Other Eligibility Coverage: This field should be selected to indicate that you have completed any additional eligibility requirement or measurement period by your employer. **Effective Date of Benefits** field is mandatory.

Cancel Enrollee: Complete Sections 1, 2, 4 and 9. In Section 4, include name, social security number and date of birth of individual(s) cancelling.

Cancel Dependent: Complete Sections 1, 2, 4 and 9. In Section 4, include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 8 and 9.

SECTIONS 2 & 3

Complete all portions related to the coverages for which you are applying.

If you work for an employer with 1-50 employees, please list the seven-character plan ID for your selected benefit design (example: B718CHC) in the Plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO only: Those applying for HMO coverage should select a Primary Care Physician (PCP) for each individual to be covered. List the name of the physician and the provider number from the provider directory or Provider Finder® at **bcbsok.com**. Be sure to check the appropriate box for a new patient.

Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address/Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2 and 9.

SECTION 5

Complete this section if you are applying for coverage for a disabled dependent child over the dependent child age limit of your employer's plan. A disabled dependent must be certified as disabled by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma. If certified disabled by Social Security, please attach a copy of the certification documentation.

SECTION 6

Complete this section if you or any dependent has other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

SECTION 7

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 8

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Sections 8 and 9, not just those declining because of other coverage.

IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, placement for adoption or placement in your home as a foster child, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or placement of an eligible foster child in your home.

SECTION 9

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer, who will then submit your form to: **Blue Cross and Blue Shield of Oklahoma • P. O. Box 3283 • Tulsa, OK 74112-3283 or via fax at 918-551-3179**.

Changes in state or federal law or regulations or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the BCBSOK website at bcbsok.com, from your marketing service representative or from your employer. If you have any questions, please contact your marketing service representative.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Oklahoma   BlueLincs HMO[SM]

Group No.	Section No.	Dept No.	Social Security No.
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8, AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Change(s)**

Are you applying as a result of a Special Enrollment Event? ☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth, Adoption, Placement for Adoption (provide Legal documents)
☐ Court Order (see instructions)
☐ Loss of Other Coverage
☐ Insure Oklahoma (O-EPIC Provide Approval Letter)
☐ Other (Explain) ______________________________

Effective Date of Benefits: ____ / ____ / ____ **NOTE:** Declination of Coverage (Complete Sections 2, 8 & 9)

☐ **Completion of Other Eligibility Coverage**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

List names of those cancelling in Section 4 below

Event: ☐ Divorce ☐ Death
☐ Terminated Employment
☐ Other

Indicate Event Date: ____ / ____ / ____

Cancel Coverage: ☐ Health ☐ Dental

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No. – –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	On average, how many hours do you work per week? (Required)

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ____________ ☐ COBRA Continuation

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (1-50 employees)

Health Coverage (select one)	Who is covered? (select one)	BlueCare Dental Coverage	Who is covered? (select one)
☐ Blue Advantage PPO[SM]	☐ Employee Only	☐ Yes	☐ Employee Only
☐ Blue Choice PPO[SM]	☐ Employee /Spouse	☐ No	☐ Employee /Spouse
☐ Blue Preferred PPO[SM]	☐ Employee /Child(ren)		☐ Employee /Child(ren)
☐ Blue Options PPO[SM]	☐ Family		☐ Family
7-character Plan # (required) ____________	☐ I am not applying for Health coverage		☐ I am not applying for Dental coverage

Large Group Plans (51 or more employees)

Health Coverage (select one)	Who is covered? (select one)	Dental Coverage	Who is covered? (select one)
☐ Blue Choice PPO[SM] ☐ Blue Traditional[SM]	☐ Employee Only	☐ Yes	☐ Employee Only
☐ Blue Preferred PPO[SM] ☐ BlueLincs HMO[SM]	☐ Employee /Spouse	☐ No	☐ Employee /Spouse
☐ Blue Options PPO[SM] ☐ HSA Blue[SM]	☐ Employee /Child(ren)	Plan # (required)	☐ Employee /Child(ren)
☐ Other ____________	☐ Family		☐ Family
Plan # ____________	☐ I am not applying for Health coverage	____________	☐ I am not applying for Dental coverage
Health Deductible Option $_____ (if more than one is available)			

Applicant's Primary Language: ______________________

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No. – –	Birth Date (MM/DD/YYYY)	Address (if different) - No. And Street Address	City	State	Zip

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Last Name: Social Security No: ___ ___ Group #

SECTION 5 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

A disabled dependent must be certified as disabled by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma.
If certified disabled by Social Security, please attach a copy of the certification documentation.

SECTION 6 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 7 — MEDICARE COVERAGE INFORMATION

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 8 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for Declining Health: ☐ Other Group Health Coverage; Carrier: _____ ☐ Indian Health Services ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining Dental: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

SECTION 9 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Oklahoma (BCBSOK). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Applicant's Signature _____ Date _____