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

*DENTAL GROUP NUMBER

*DENTAL DIVISION NUMBER

*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

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*TYPE OF HEALTH COVERAGE SELECTED

☐ SINGLE ☐ FAMILY ☐ EMP +1

*TYPE OF DENTAL COVERAGE SELECTED

☐ SINGLE ☐ FAMILY ☐ EMP +1

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 ☐ 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 ☐ 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 ☐ 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 ☐ MALE ☐ FEMALE

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

DEPENDENT

*LAST NAME	*FIRST NAME

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

*RELATIONSHIP	*GENDER	*DATE OF BIRTH (MM/DD/YYYY)
☐ SPOUSE ☐ CHILD ☐ OTHER _____	☐ MALE ☐ FEMALE	/ /

DEPENDENT

*LAST NAME	*FIRST NAME

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

*RELATIONSHIP	*GENDER	*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 and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification, please 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	☐ CANCEL CONTRACT	☐ CHANGE CONTRACT	☐ ADD DEPENDENT ☐ Spouse ☐ Child
	☐ Medical Coverage ☐ Dental Coverage ☐ Medical & Dental Coverage	☐ 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.

THE GROUP PLAN UNDER WHICH YOU ARE APPLYING FOR COVERAGE INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT OTHER THAN A CLAIM FOR BENEFITS UNDER SECTION 502(a) OF ERISA WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE GROUP PLAN.

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
Baldwin County Commission	42257

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
312 Courthouse Sq, Ste 17 Bay Minette AL 36507	(251)-937-0337

PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION
Bo Bonner	X

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