ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Oklahoma   BlueLincs HMO℠

Group # ______ Section # ______ Social Security # ______
Account # ______ 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 Changes**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ New Hire ☐ Marriage* ☐ Birth
☐ Adoption (provide legal documents)
☐ Court Order (provide court order or decree)
☐ Loss of Other Coverage
☐ Insure Oklahoma (O-EPIC approval letter required)
☐ Other (explain): ______

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

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

Cancel Coverage: ☐ Health ☐ Dental

List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death ☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF
COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security # – –

Mailing Address - Street - Apt #	City	State	ZIP code

Email Address	☐ Male ☐ Female	Home/Cell Phone #

Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	On average, how many hours a week do you work? (required)

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ______

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℠ ☐ Blue Choice PPO℠ ☐ Blue Preferred PPO℠ ☐ Blue Options PPO℠ ☐ Other______ Plan # (required) ______	☐ Employee Only ☐ Employee /Spouse*** ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required) ______	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ 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 Advantage PPO℠ ☐ Blue Options Select PPO℠ ☐ Blue Choice PPO℠ ☐ Blue Traditional® ☐ Blue Preferred PPO℠ ☐ BlueLincs HMO℠ ☐ Blue Options PPO℠ ☐ HSA Blue℠ ☐ Other ______ Plan # (required) ______ Health Deductible Option $_____ (if more than one is available)	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required) ______	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Dental coverage

Primary Language: ______

SECTION 4 — COVERAGE OPTIONS
PLEASE COMPLETE ALL AREAS THAT APPLY

Employee/Enrollee's Name	PCP Name	PCP #	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N

Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, adopted child or foster child? ☐ Y ☐ N	If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, adopted child or foster child? ☐ Y ☐ N	If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, adopted child or foster child? ☐ Y ☐ N	If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.

** The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).*
*** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).*
**** The term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).*

Last Name: Social Security #: ___ — ___ Group #

SECTION 5 — DISABLED DEPENDENT PLEASE COMPLETE IF APPLICABLE

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

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Request to Extend Coverage for Disabled Dependent form.

SECTION 6 — OTHER COVERAGE INFORMATION PLEASE COMPLETE ALL AREAS THAT APPLY

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

Group Coverage ☐ Yes ☐ No	Individual 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 #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION PLEASE COMPLETE IF APPLICABLE

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 # (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 # (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 PLEASE COMPLETE IF YOU ARE DECLINING 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: _____ ☐ 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 ☐ 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 ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ 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 or a retiree 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 underwritten or administered by Blue Cross and Blue Shield of Oklahoma. 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 Contract(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 _____