BCBS

EMPLOYEE APPLICATION

EFFECTIVE DATE OF COVERAGE

BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE
- ○ PPO Base
- ○ PPO Buy Up
- ○ Saver HDHP
- ○ Other

} _____ OPTION

MEDICAL COVERAGE
- ○ EMPLOYEE ONLY
- ○ EMPLOYEE & SPOUSE
- ○ EMPLOYEE & CHILDREN
- ○ FAMILY

ARE YOU DECLINING COVERAGE FOR:

	MEDICAL _____
SELF?	○ Y ○ N
SPOUSE?	○ Y ○ N
DEPENDENT(S)?	○ Y ○ N

If yes, include the appropriate reason code(s) in Section II below. (A list of reason codes is found near the bottom of page 2.)

- ○ NEW GROUP OPEN ENROLLMENT

SECTION I – INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME | LOCATION | GROUP NUMBER | JOB CLASSIFICATION ○ I ○ II ○ OTHER (SEE EMPLOYER)

SECTION II – INFORMATION REGARDING THE EMPLOYEE

MARK ONE: ○ ADD ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

SOCIAL SECURITY NUMBER Required. See (O) on page 2. | LAST NAME | FIRST NAME | M.I.

PHYSICAL ADDRESS (NUMBER, STREET & APARTMENT NO.) | CITY | STATE | ZIP + FOUR

MAILING ADDRESS | CITY | STATE | ZIP + FOUR

DATE OF BIRTH (MM/DD/YYYY) | MALE ○ | FEMALE ○ | MARRIED ○ | SINGLE ○ | DATE OF MARRIAGE (MM/DD/YYYY) | WORK TELEPHONE (AREA CODE AND NO.) | HOME TELEPHONE (AREA CODE AND NO.)

EMAIL ADDRESS | See page 2 (N) regarding e-mail authorization

OTHER COVERAGE INFORMATION: Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES ○ NO ○
If yes, please complete the other coverage information below.

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | ID/SOCIAL SECURITY NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

Complete the following for all dependents. If you have more than 3 dependents, complete a separate form.
New employees: Complete the following information for each eligible dependent including those declining or waiving coverage.
Enrolled employees: to add or remove dependent(s) or change coverage options, only include the persons affected by the change.

1 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

2 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

3 MARK ONE: ○ ADD ○ DELETE ○ CHANGE ○ WAIVER
CODE ____ (SEE BACK)

LAST NAME | FIRST NAME | M.I.

SOCIAL SECURITY NUMBER Required. See (O) on page 2 | DATE OF BIRTH (MM/DD/YYYY) | MALE ○ FEMALE ○ | RELATIONSHIP

OTHER HEALTH PLAN COVERAGE NAME | CARRIER PHONE NO. (AREA CODE & NO.) | POLICY HOLDER LAST NAME | IDENTIFICATION NUMBER

GROUP/POLICY NO. | EFFECTIVE DATE (MM/DD/YYYY) | MEDICARE CARD NO. | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

I certify to all of the following on behalf of myself and the persons listed on this application as eligible dependents: (1) I have read this entire form, (2) I understand and agree to its terms; (3) I apply for enrollment and/or waive group benefits as indicated on this form, subject to all terms and conditions of the coverage, as offered by my employer; (4) the information I have provided is accurate and complete, and I understand that provision of false information may result in fines and criminal penalties; and (5) if any part of any premium for coverage or other financial services will be paid through payroll deduction, I authorize my employer to periodically deduct from my wages, and remit amounts necessary to continue the coverage and any services.

X _____
EMPLOYEE'S SIGNATURE

_____
DATE

PAGE 1 OF _____ PAGE 2 OF _____ PAGE 3 OF _____

BlueCross BlueShield of Arizona
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