

Application

**For Enrollment without
Binding Arbitration**

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001



An Independent Licensee of the Blue Cross and Blue Shield Association.



Fields marked with an *are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

* HEALTH GROUP NUMBER	* HEALTH DIVISION NUMBER	* DENTAL GROUP NUMBER	* DENTAL DIVISION NUMBER	* VISION GROUP NUMBER	* VISION DIVISION NUMBER
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***NATURE OF APPLICATION** (Check all that apply)

NEW CONTRACT	CANCEL CONTRACT	CHANGE CONTRACT
HEALTH DENTAL VISION	HEALTH DENTAL VISION	NAME CHANGE ADDRESS CHANGE TYPE COVERAGE CHANGE

ENROLLMENT PERIOD (for new contracts)

REGULAR ENROLLMENT	ANNUAL OPEN ENROLLMENT	SPECIAL OPEN ENROLLMENT
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*LAST NAME	*FIRST NAME
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MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
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*HOME MAILING ADDRESS

*CITY	*STATE	*ZIP
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*PHONE NUMBER HOME WORK CELL	E-MAIL ADDRESS (Optional)
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*GENDER MALE FEMALE	*DATE OF BIRTH (MM/DD/YYYY)
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*EMPLOYEE NUMBER

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

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 OTHER CHILD SPOUSE	*GENDER MALE FEMALE	*DATE OF BIRTH (MM/DD/YYYY)					
	ADD DEPENDENT	QUALIFYING EVENT TYPE: Marriage Birth/Adoption Loss of Coverage Other	* DATE EVENT OCCURRED					
	REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: Divorce Death Entered Military Service Request	* DATE EVENT OCCURRED					
	ADD HEALTH	ADD DENTAL	ADD VISION	ADD ALL	REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

DEPENDENT	*LAST NAME	*FIRST NAME						
	MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER					
	*RELATIONSHIP OTHER CHILD SPOUSE	*GENDER MALE FEMALE	*DATE OF BIRTH (MM/DD/YYYY)					
	ADD DEPENDENT	QUALIFYING EVENT TYPE: Marriage Birth/Adoption Loss of Coverage Other	* DATE EVENT OCCURRED					
	REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: Divorce Death Entered Military Service Request	* DATE EVENT OCCURRED					
	ADD HEALTH	ADD DENTAL	ADD VISION	ADD ALL	REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

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DEPENDENT	*LAST NAME				*FIRST NAME			
	MAIDEN/MIDDLE NAME				SUFFIX (JUNIOR, SENIOR)		*SOCIAL SECURITY NUMBER	
	*RELATIONSHIP OTHER	CHILD	SPOUSE	*GENDER	MALE	FEMALE	*DATE OF BIRTH (MM/DD/YYYY)	
	ADD DEPENDENT	QUALIFYING EVENT TYPE: Marriage Birth/Adoption Loss of Coverage Other				* DATE EVENT OCCURRED		
	REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: Divorce Death Entered Military Service Request				* DATE EVENT OCCURRED		
	ADD HEALTH	ADD DENTAL	ADD VISION	ADD ALL	REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

DEPENDENT	*LAST NAME				*FIRST NAME			
	MAIDEN/MIDDLE NAME				SUFFIX (JUNIOR, SENIOR)		*SOCIAL SECURITY NUMBER	
	*RELATIONSHIP OTHER	CHILD	SPOUSE	*GENDER	MALE	FEMALE	*DATE OF BIRTH (MM/DD/YYYY)	
	ADD DEPENDENT	QUALIFYING EVENT TYPE: Marriage Birth/Adoption Loss of Coverage Other				* DATE EVENT OCCURRED		
	REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: Divorce Death Entered Military Service Request				* DATE EVENT OCCURRED		
	ADD HEALTH	ADD DENTAL	ADD VISION	ADD ALL	REMOVE HEALTH	REMOVE DENTAL	REMOVE VISION	REMOVE ALL

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 after age 26, please list any dependent child applying for student extension.

NAME OF CHILD		NAME OF SCHOOL	
NAME OF CHILD		NAME OF SCHOOL	

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health, dental and/or vision 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 SINGLE 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.

If you have Individual coverage, please call Customer Service at **1-855-350-7441** to cancel your contract. If your Individual coverage is through the Federal Marketplace, please call the Marketplace at **1-800-318-2596** to cancel your contract.

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 C	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 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 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, dental and/or vision 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.

***SIGNATURE OF EMPLOYEE**

DATE SIGNED (MM/DD/YYYY)		FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)	
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TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME		*GROUP NUMBER
EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
PRINTED GROUP ADMINISTRATOR NAME		GROUP ADMINISTRATOR EXTENSION
*GROUP ADMINISTRATOR'S SIGNATURE		DATE SIGNED (MM/DD/YYYY)

IMPORTANT DISCLOSURE NOTICE

NOTICE OF GROUP HEALTH, DENTAL AND VISION PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health, dental and/or vision plan benefits for yourself or your dependents (including your spouse) because of other health, dental and/or vision insurance or group health, dental and/or vision plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement as an eligible foster child, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, placement for adoption, or placement as an eligible foster child.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

NOTICE OF GROUP DENTAL PLAN BENEFIT WAITING PERIODS

This dental plan includes benefit waiting periods that you may have to serve before certain benefits begin to be covered under this dental plan. Please refer to the section in your benefit booklet called "Benefit Waiting Periods."

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE FOR GROUP HEALTH PLANS

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.

