



MEDICAL PLAN TYPE <input type="radio"/> BLUEPREFERRED (PPO) <input type="radio"/> BLUECLASSIC (INDEMNITY) <input type="radio"/> BLUECHOICE (HMO) <input type="radio"/> BLUESELECT (HMO) <input type="radio"/> BLUEADVANTAGE (OPEN ACCESS)		} \$ _____ DEDUCTIBLE	WAIVER OF COVERAGE <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT(S)
MEDICAL COVERAGE <input type="radio"/> EMPLOYEE ONLY <input type="radio"/> EMPLOYEE & SPOUSE <input type="radio"/> EMPLOYEE & CHILD(REN) <input type="radio"/> FAMILY	DENTAL CHOICE COVERAGE <input type="radio"/> EMPLOYEE ONLY <input type="radio"/> EMPLOYEE & SPOUSE <input type="radio"/> EMPLOYEE & CHILD(REN) <input type="radio"/> FAMILY		FOR THOSE EMPLOYEES AND DEPENDENTS DECLINING COVERAGE, SELECT THE APPROPRIATE REASON CODE FROM THE BACK OF THIS FORM, AND ENTER BELOW.
LIFE ONLY (IF OFFERED BY EMPLOYER) <input type="radio"/> YES <input type="radio"/> NO			

INFORMATION REGARDING YOUR EMPLOYER		
EMPLOYER NAME	GROUP NUMBER	WORK PHONE NO. (AREA CODE AND NO.)

INFORMATION REGARDING THE EMPLOYEE				
MARK ONE: <input type="radio"/> ADD <input type="radio"/> CHANGE <input type="radio"/> DELETE <input type="radio"/> WAIVER CODE _____ (SEE BACK)	SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.
	APARTMENT NO.	MAILING ADDRESS (NUMBER & STREET)		
CITY		STATE	ZIP + FOUR	HOME TELEPHONE (AREA CODE & NO.)

DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE	MARRIED SINGLE	DATE OF MARRIAGE (MM/DD/YYYY)	HOURS WORKED PER WEEK	DATE OF FULLTIME EMPLOYMENT	CLASS
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OTHER CARRIER INFORMATION: Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES NO
 If you currently have or have had other health coverage within the last 18 months, please complete the other carrier information below.

CARRIER NAME	CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER NAME	ID / SOCIAL SECURITY NUMBER
GROUP / POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL 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.
 If any of your dependents currently have or have had other health coverage within the last 18 months, please complete the other carrier information for each covered dependent.
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: <input type="radio"/> ADD <input type="radio"/> CHANGE <input type="radio"/> DELETE <input type="radio"/> WAIVER CODE _____ (SEE BACK)	LAST NAME	FIRST NAME			M.I.
	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE	RELATIONSHIP	
NAME OF OTHER INSURANCE CARRIER		CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER NAME	ID / SOCIAL SECURITY NUMBER	
GROUP / POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)	MEDICARE CARD NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

2 MARK ONE: <input type="radio"/> ADD <input type="radio"/> CHANGE <input type="radio"/> DELETE <input type="radio"/> WAIVER CODE _____ (SEE BACK)	LAST NAME	FIRST NAME			M.I.
	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE	RELATIONSHIP	
NAME OF OTHER INSURANCE CARRIER		CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER NAME	ID / SOCIAL SECURITY NUMBER	
GROUP / POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)	MEDICARE CARD NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

3 MARK ONE: <input type="radio"/> ADD <input type="radio"/> CHANGE <input type="radio"/> DELETE <input type="radio"/> WAIVER CODE _____ (SEE BACK)	LAST NAME	FIRST NAME			M.I.
	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE	RELATIONSHIP	
NAME OF OTHER INSURANCE CARRIER		CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER NAME	ID / SOCIAL SECURITY NUMBER	
GROUP / POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)	MEDICARE CARD NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

Are any of the dependents age 19 or over applying for this coverage currently considered disabled and chiefly dependent upon the employee for financial support? YES NO

Complete this section for life insurance through Medical Life Insurance Company/Fort Dearborn Life. Gross Income \$ _____ <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Year		If applicable, check all types of insurance that apply <input type="radio"/> Group Life/Disability <input type="radio"/> Dependent Life <input type="radio"/> Supplemental Life \$ _____	BENEFICIARY NAME	RELATIONSHIP
			CONTINGENT BENEFICIARY	RELATIONSHIP

I certify that having read this entire form, including the information on the reverse and (1) I understand and agree to its terms and (2) I apply for enrollment and/or waive group benefits and (3) the information I have provided is accurate and complete.

X _____
 EMPLOYEE'S SIGNATURE

_____ DATE

BlueCross BlueShield of Arizona
 An Independent Licensee of the Blue Cross and Blue Shield Association
 www.bcbsaz.com
EMPLOYEE APPLICATION

Blue Cross / Blue Shield Application Instructions

1. Remember to choose plan desired in Section C.
2. Each question must be answered for **all** family members applying for coverage.
3. Any "yes" answers must be explained in full.
4. **DO NOT USE WHITE OUT.** If you make a mistake, cross it out, initial the change and put the correct answer next to it.
5. Be sure to sign the application where indicated on page 3 and below the health questions on page 2. **Do Not Date The Application Until You Are Ready to Return to Us.** If coverage is for a child only, the parent or legal guardian must endorse the application.
6. If you should run out of room for any "yes" answers, include a separate sheet with the additional details. All applicants must sign the additional sheets or your application may be returned.
7. Remember to include the \$20 application processing fee made out to Blue Cross.
8. It is not necessary to include the first month premium. Only send the \$20.00

Please initial these items and return this form along with your application.

_____ I have reviewed the benefit outline contained in the sales brochure describing the policy.

_____ I have checked each question and explained all "yes" answers.

_____ I have reviewed and / or have read the list of exclusions / limitations that are listed in the sales brochure.

_____ I have signed where indicated on the application and on any additional information sheets.

_____ I am enclosing a check for the first month's premium payable to the insurance company.

_____ If requesting a monthly payment. I have signed the Automatic Withdrawal form and enclosed a voided check for the appropriate account.

_____ I realize that this initial check may be cashed, but that it is fully refundable if not approved.

_____ I will continue my current coverage, if applicable, until the insurance company has accepted me.

_____ I realize that effective dates are NOT GUARANTEED and totally contingent on approval by the insurance company.

_____ I realize that any requests for medical records or additional information may slow the approval process.

_____ I also realize that any past medical history may result in a higher premium and / or restricted coverage.

_____ I understand that this policy is not "Guaranteed Issue" and can be declined or otherwise altered.

_____ I further understand that if prior medical information is knowingly excluded from the application that my future insurability could be affected.

_____ I am in receipt of and have read the Privacy Notice and the Portability Statement.

Please Return. We Cannot Process Your Application Without This Form

If you have any further questions or concerns, please call us at 623-435-8400 and we will be glad to help.