BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

MEMBERSHIP APPLICATION AND CHANGE FORM

REQUIRED EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI):_____ **2.** Birthdate:____/____/____ **3.** Male ☐ Female ☐
4. Address (Street):_____ (City):_____ (State):_____ (ZIP):_____
5. Employee Social Security Number (Required): _____ **6.** Phone (Required): (___) _____Cellphone: ☐ Yes ☐ No
7. Email (Required):_____ **8.** Name of Employer:_____
9. Effective Date of Action Requested:____/____/____ **10.** Tobacco Use* (small group only): ☐ Yes ☐ No

REASON FOR APPLICATION

11. ☐ New Member – Full-Time Employee; Full-Time Date of Hire:_____/_____/_____
☐ Coverage Change – Reason for Change:_____ Date of Occurrence:_____/_____/_____
☐ Cancellation – Date Left Employment:_____/_____/_____
☐ Reinstatement – Reason: ☐ Return from Layoff ☐ Return from Leave
☐ COBRA/State Continuation:_____ Start Date:_____/_____/_____
12. Group Number (if known for changes to existing plan):_____

COVERAGE INFORMATION

13. Plan Choice:_____

14. MEDICAL ELECTION
☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Family

☐ No Medical Coverage Due To (Check one):
☐ Other BlueChoice® Coverage (01)
☐ Covered by Military (03)
☐ Insurance With Another Company (02)
☐ Covered by Medicare (12)
☐ Covered by Spouse With This Employer (07)
☐ Other (05); Explain:_____

15. DENTAL ELECTION (if applicable)
☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren)
☐ Family ☐ No Dental Coverage

16. LIFE COVERAGE (if applicable) (underwritten by Companion Life)**
☐ Life Only (No Medical) ☐ Life and AD&D ☐ Dependent Life
☐ STD ☐ LTD ☐ No Life Coverage
Life Amount: $_____ Life Class:_____ **Earnings:** $_____
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Beneficiary Designation *(All Plans – applicable only if life coverage is available and selected)*
Primary:_____ Relationship:_____
Contingent:_____ Relationship:_____

ENROLLMENT INFORMATION (List all individuals to be covered.)

17.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Other Insurance Yes	Other Insurance No	Tobacco Use * Yes	Tobacco Use * No
Spouse						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐

*** Please indicate whether any person age 21 or older has used tobacco four or more times a week in the last six months.**

OTHER COVERAGE INFORMATION

18. If you or any of your family members have other health (including Medicare), dental or drug coverage other than with this employer, what is the name of the insurance company and the policyholder's ID number?_____

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*

I authorize release to BlueChoice HealthPlan or its representatives all past and future medical records for myself and eligible dependents and other information deemed necessary by BlueChoice to review, process or investigate claims. This authorization includes Medicare Parts A and B claims. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated, or claims denied, if fraud or intentional misrepresentations of material facts have been made on this application, subject to the Incontestability provision. The statements made herein are complete and true to the best of my knowledge.

BlueChoice HealthPlan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Signature:_____ **Date**:_____

**Companion Life is a separate life insurance company that does not provide BlueChoice products or services. Companion Life is solely responsible for all services related to its life insurance.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)