BlueCross BlueShield of Oklahoma

BlueLincs HMO℠

Group Enrollment Application | Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

603316.0817

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 **ENROLLMENT EVENTS**	Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection. **New Enrollee:** Complete all sections where applicable. **Add Dependent:** Complete all sections where applicable. • If you are adding or enrolling a dependent due to adoption or placement for adoption, you must provide legal documents. • If you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree. • Employees must notify Blue Cross and Blue Shield of Oklahoma (BCBSOK) within 31 days of the birth of a newborn child, date a child is adopted/ placed in their home for adoption, or eligible foster child placed in their home. You must provide legal documents, a court order or decree. If BCBSOK is notified after 31 days, the child may not be eligible to apply for coverage until the next open enrollment period. **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership. **Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **Effective Date of Benefits:** Field is mandatory and should reflect your requested date. **Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.
SECTION 2 **YOUR INFORMATION**	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 **YOUR COVERAGE**	Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: B718CHC) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.
SECTION 4 **COVERAGE OPTIONS**	Complete all areas that apply to you and each dependent. **For HMO Plans Only:** • Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at **bcbsok.com**. Be sure to check the appropriate box for a new patient. **Change Primary Care Physician/Practitioner:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP. **Change Address/Name:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 **DISABLED DEPENDENT**	A dependent child who is medically certified as disabled and dependent upon the member or his/her spouse*** or domestic partner (provided the group covers domestic partners) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A Request to Extend Coverage for Disabled Dependent form must be completed and submitted with this enrollment application, if applicable.
SECTION 6 **OTHER COVERAGE**	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 **MEDICARE COVERAGE**	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 **DECLINATION OF COVERAGE**	Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 8, not just those declining because of other coverage. **IMPORTANT NOTICE:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption or placement of an eligible foster child in your home.
SECTION 9 **COVERAGE CONDITIONS**	Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to: **BCBSOK • PO Box 3283 • Tulsa, OK 74112-3283 or via fax at 918-551-3179.**
	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 and a party to a domestic partnership (coverage subject to your employer's plan).*

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Oklahoma website at bcbsok.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.

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 Choice PPO℠ ☐ Blue Traditional® ☐ Blue Preferred PPO℠ ☐ BlueLincs HMO℠ ☐ BlueOptions℠ ☐ HSA Blue℠ ☐ Blue Options Select PPO℠ ☐ 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	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient?
☐ Son ☐ Daughter ☐ Other Eligible Dependent	– –			☐ 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	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient?
☐ Son ☐ Daughter ☐ Other Eligible Dependent	– –			☐ 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	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient?
☐ Son ☐ Daughter ☐ Other Eligible Dependent	– –			☐ 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 _____

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
မြန်မာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် 855-710-6984 သို့ ခေါ်ဆိုပါ။.
ᏣᎳᎩ Cherokee	ᏂᎯᏃ, ᎠᎴ ᎩᎶ ᏴᏫ Ꮎ ᎯᏍᏕᎵᏍᎨᎩ, ᏣᏛᏅ Ꮕ ᏜᏍ ᏍᏕᏍ, Ꮒ Ꭿ Ꮆ Ꮙ Ꮎ ᏍᎩ Ꭱ Ꮆ Ꮅ ᏍᏕ Ꮙ Ꮭ Ꭰ Ꮄ Ꭱ Ꮆ Ꮓ Ꮞ Ꮭ Ꮯ Ꮺ Ꮆ Ꮼ Ꮒ ᎯᏍᏗ Ꭼ ᏔᎾ Ꭹ Ꭰ Ꮞ ᏉᏉ. Ꭰ Ꮎ ᏁᏢ Ꮭ ᏍᎩ ᏍᏓ Ꮬ Ꮓ Ꮘ Ꮭ Ꭲ , Ꮻ Ꮟ ᏔᏅ Ꭹ 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Hmoob Hmong	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug kwstxhais lus tham, hu rau 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک مي کنيد، سؤالی داشته باشيد، حق اين را داريد که به زبان خود، به طور رايگان کمک و اطلاعات دريافت نماييد. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نماييد.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนทีคุณกาลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิทีจะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อที่หมายเลข 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، پر 855-710-6984 کال کریں۔.
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html