			EMPLOY	EE /	APF	PLICATIO	N	O NE	W GROUP	0	PEN ENROLLMENT	
EFFECTIVE DATE OF COVERAGE	DDO DDO		D* PLAN NAMI	E	_	EMPLOYEE & SPO	USE	ARE YOU DECLIN	ME	DICAL	DENTAL	-
BCBSAZ ID NUMBER (existing r	nember) PPO HSA HMO HSA DENTAL	QUALIFIE	D* DEDUCTIBL COINSURAN		_	EMPLOYEE & CHIL FAMILY DENTAL COVERAGE EMPLOYEE ONLY		SELF? SPOUSE? DEPENDENT(S)?	O _Y	000		N.
EMPLOYEE NUMBER (employer	PLAN NAME	_	EMPLOYEE & SPOUSE EMPLOYEE & CHILDREN FAMILY			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.)						
CONSUMER-DIRECTED HEAL	THCARE ACCOUNTS:											
Health Savings Account (I			nbursement Arrangement (Hi ending Account (FSA)	RA)) Depen	dent-Care Flexible Spend Accounts in this s		ount (DCFSA) oust be offered by emplo		ose Flexible	Spending Account (L	PFSA)
SECTION I – INFORMATIO	N REGARDING YOUR EM	PLOYER										
EMPLOYER NAME						LOCATION	GROU	JP NUMBER	JOB CLASSIF		OTHER (SEE EMPLO	YER)
SECTION II – INFORMATION	ON REGARDING THE EMP	LOYEE					ı			<i></i>	2	,
MARK ONE: O ADD CHANGE		FIRST N	AME				M.I.					
WAIVER PHYSICAL CODE SACK)		CITY	ITY			ZIP + FOUR						
MAILING ADDRESS		CITY			STATE	ZIP + FOUR						
DATE OF BIRTH (MM/DD/YYY	DATE OF MARRIAGE (MM/DD/YYYY) WORK TELEPHONE (AREA O				ODE ANI	D NO.)	HOME TELEP	HONE (ARI	EA CODE AND NO.)			
EMAIL ADDRESS		10							See	page 2 (N) regarding	
										l authoi		
INFORMATION:	Will you or your dependent If yes, please complete the		overage information bel	ow.				NO O				
OTHER HEALTH PLAN COVER	AGE NAME		CARRIER PHONE NO. (AF	REA CODE 8	& NO.)	POLICYHOLDER LAST	NAME		ID/S00	CIAL SECU	RITY NUMBER	
GROUP/POLICY NO.	MEDICARE CARD NO.				PART A EFFECTIVE DATE PART B EFFECTIVE			FFECTIVE DATE				
dependent including those	or all dependents. If you I e declining or waiving cove						je cove	rage options, only				
O ADD	ME						FIF	RST NAME				M.I.
WAIVER Required.	ECURITY NUMBER . See (0) on page 2	DATE 0	F BIRTH (MM/DD/YYYY)		FEMALE	RELATIONSHIP						
OTHER HEALTH PLAN COVER	CARRIER PHONE NO. (AREA CODE & NO.) POLICYHOLDER LAS				NAME IDENTIF			FICATION NUMBER				
GROUP/POLICY NO. EF	MEDICARE CARD NO.				PAR1	T A EFFECTIVE DATE		PART B E	FFECTIVE DATE			
					<u> Ц</u>							
2 MARK ONE: LAST NA	ME						FIR	IST NAME				M.I.
O DELETE O CHANGE WAIVER SOCIAL S Required.	ECURITY NUMBER See (0) on page 2	DATE O	F BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP						<u> </u>
CODE (SEE BACK) OTHER HEALTH PLAN COVER.	ACE NAME		CARRIER RUONE NO. /AR	O	0	POLICYHOLDER LAST	NABAE		LIDENTI	FICATION	NUMBER	
OTHER HEALTH FLAN COVER	AUE NAME		CARRIER PHONE NO. (AR	IEA GUDE O	(NU.)	PULICIHULDER LASI	NAIVIE		IDENTI	FIGATION	NUMBER	
GROUP/POLICY NO. EF	MEDICARE CARD NO.				PART	ART A EFFECTIVE DATE			PART B EFFECTIVE DATE			
MARK ONE: LAST NA	ME						FIR	IST NAME				M.I.
O DELETE	ECURITY NUMBER	DATE O	F BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP						
WAIVER Required.	See (0) on page 2	DATE OF	- D (mm/DD/1111)	IIIIILL	LIMITEL							
CODE (SEE BACK)	AOF MARKE		Loappier	0	0	DOLLOV::			1	F10.7=1	WILLIAM TO	
OTHER HEALTH PLAN COVER	AGE NAME		CARRIER PHONE NO. (AR	EA CODE 8	NO.)	POLICYHOLDER LAST	NAME		IDENTI	FICATION	NUMBER	
GROUP/POLICY NO. EFFECTIVE DATE (MM/DD/YYYY)			MEDICARE CARD NO.				PART	A EFFECTIVE DATE		PART B E	FFECTIVE DATE	
											(0)	

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.





ACKNOWLEDGMENTS, AGREEMENTS, AND AUTHORIZATIONS APPLICABLE TO EMPLOYMENT-BASED HEALTH BENEFIT PLAN COVERAGE OFFERED BY OR ADMINISTERED THROUGH BLUE CROSS BLUE SHIELD OF ARIZONA (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association

On behalf of myself and the persons listed on this application as eligible dependents, I acknowledge, agree, and authorize the following:

- A. I have received information summarizing the terms and conditions of the health coverage available through my employment ("Coverage"). The Coverage is either (a) group health insurance that my employer has purchased from BCBSAZ; or (b) a group benefit plan, for which BCBSAZ provides certain administrative, claims payment, and utilization management services, and provider network access, but does not assume financial risk or obligation for claims.
- B. I have carefully reviewed this entire application form and the answers I've provided. My answers are material to BCBSAZ BCBSAZ will rely on my information to determine my employer group's eligibility for BCBSAZ coverage or administrative services, and to establish premium rates or administrative fees for my employer group.
- C. My application includes any other enrollment forms I complete when applying for this coverage. This completed application becomes a part of my group's contract with BCBSAZ, except for any provisions related to life and disability coverage or separate financial accounts (HSA, FSA, HRA).
- D. BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan. BCBSAZ is independent from any companies that offer such coverage.
- E. BCBSAZ does not administer or guarantee any separate financial account or arrangement (HSA, HRA, FSA) that may be part of the group benefit plan sponsored by my employer. BCBSAZ is independent from any companies that administer such coverage or accounts.
- F. My coverage shall become effective only when BCBSAZ: (1) reviews and accepts this application and (2) issues coverage to my employer group and me on effective dates assigned by BCBSAZ in accordance with the employer's terms for coverage.
- G. The contract between my employer group and BCBSAZ controls the administration of this group coverage. The Coverage is subject to change, as permitted under applicable state and federal law, and in accordance with the terms of the contract between my employer and BCBSAZ. My employer is responsible for notifying me of all changes, including termination of the employer group contract for any reason.
- H. If the contract between my employer group and BCBSAZ is terminated, I may be eligible for other coverage as required under state and/or federal law.
- I. BCBSAZ, its reinsurers, or their respective authorized representatives may need to obtain medical information to process claims, and may collect personal information from someone other than me or one of the proposed covered persons. I authorize any physician, practitioner, hospital, clinic, or other health-related provider or facility to furnish my health information, including information related to drug use, alcoholism, mental illness, HIV, and AIDS (but not genetic testing or family history), to BCBSAZ, its reinsurers, and their respective authorized representatives. BCBSAZ may use this information, and any of my information already in its possession to process claims. When permitted by law BCBSAZ may disclose this information to third parties without my permission.
- J. If I am declining enrollment for myself or my dependents (including my spouse) because of other health or dental coverage, I may be able to enroll myself and my dependents in this BCBSAZ plan if my dependents or I lose eligibility for the other coverage (or if the employer group stops contributing towards my or my dependents' other coverage). I must request enrollment in this Coverage within 30 days after other coverage ends. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet.
- K. If I have a new dependent as a result of marriage, birth, adoption, or placement of adoption, I may be able to enroll myself and/or my dependents, if I request enrollment within 31 days (60 days for small groups*) after marriage, birth, adoption, or placement of adoption. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet. (To request special enrollment or obtain more information contact: Group Enrollment Services at 602-864-4456 or 1-800-232-2345, ext. 4456.)
- L. Information regarding other health plan coverage is not used to determine preexisting conditions for BCBSAZ plans beginning or renewing on or after January 1, 2014.
- M. I am responsible for any costs associated with obtaining medical records needed to process claims.
- N. By including my email address on this form, I authorize BCBSAZ to send me information via email. I can change my email address or rescind this permission at any time by contacting BCBSAZ through azblue.com.
- O. Federal statute and BCBSAZ business processes require BCBSAZ or my employer plan sponsor to obtain the Social Security number (SSN) for most applicants.

Reason Codes for Declining/Waiving Coverage

(subject to BCBSAZ's Group Underwriting Participation Guidelines)

- A Does not wish to be covered no other coverage
- B Covered by spouse's or parents' employer group plan
- C Covered by TRICARE
- D Covered by AHCCCS
- E Covered by IHS (Indian Health Services)

- F Covered by Medicare
- **G** Married Coworkers
- H Individual coverage purchased directly from carrier
- I Individual coverage purchased on Healthcare Marketplace

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de BCBSAZ, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884. Díí kwe'é atah nilínigií Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éi doodago Háida bíjá anilyeedígií t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólo díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'g doo bagh ilínígóó. Ata' halne'ígií koj' bich'j' hodilnih 1-877-475-4799.

^{*} Employers are considered small groups for purposes of the Affordable Care Act (ACA) if the average number of total employees on business days during the previous calendar year is 50 or fewer.