ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Oklahoma — BlueLincs HMO℠

909300				
Group No.	Section No.	Dept No.	Social Security No.	
Group No.	Section No.	Dept No.	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 Change(s)**

Are you applying as a result of a Special Enrollment Event? ☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth, Adoption, Placement for Adoption (provide Legal documents)
☐ Court Order (see instructions)
☐ Loss of Other Coverage (provide Certificate of Creditable Coverage)
☐ Insure Oklahoma (O-EPIC Provide Approval Letter)
☐ Other (Explain) ______________________

NOTE: Declination of Coverage (Complete Sections 2, 8 & 9)

☐ **Cancel Enrollee** ☐ **Cancel Dependent**
List names of those cancelling in Section 4 below
Event: ☐ Divorce ☐ Death
☐ Terminated Employment
☐ Other
Indicate Event Date: ____ / ____ / ____

Cancel Coverage: ☐ Health ☐ Dental

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No.
					– –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	On average, how many hours do you work per week? (Required)
Becco Contractors Inc				

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ______________ ☐ COBRA Continuation

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 employees)

Health Coverage (select one)	**Who is covered? (select one)**	**BlueCare Dental Coverage**	**Who is covered? (select one)**
☐ Blue Choice PPO℠ ☐ Blue Preferred PPO℠ ☐ Blue Options PPO℠ 7-character Plan # (required) ________	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No	☐ 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℠ ☐ Blue Options PPO℠ ☐ HSA Blue℠ ☐ Other ________ Plan # ________ 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

Applicant's Primary Language: ______________________

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	Birth Date (MM/DD/YYYY)	Address (if different) - No. And Street Address	City	State	Zip
– –					

Dependent's Name: ________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N

Dependent's Name: ________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N

Dependent's Name: ________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child, or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N

Please sign on back page

Last Name: Social Security No: — — Group #

SECTION 5 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

A disabled dependent must be certified as disabled by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma.
If certified disabled by Social Security, please attach a copy of the certification documentation.

SECTION 6 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered:**

Group 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 No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 7 — MEDICARE COVERAGE INFORMATION

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 No. (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 No. (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

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: _____ ☐ Indian Health Services ☐ 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 ☐ Indian Health Services ☐ 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 ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ 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 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 either underwritten or administered by Blue Cross and Blue Shield of Oklahoma (BCBSOK). 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 Contracts(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 _____