BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE
- ⬭ BLUEPREFERRED (PPO)
- ⬭ BLUEPREFERRED SAVER (PPO)
- ⬭ BLUECLASSIC (INDEMNITY)
- ⬭ BLUECHOICE (HMO)
- ⬭ BLUESELECT (HMO)

OPTION ______

MEDICAL COVERAGE
- ⬭ EMPLOYEE ONLY
- ⬭ EMPLOYEE & SPOUSE
- ⬭ EMPLOYEE & CHILDREN
- ⬭ FAMILY

DENTALCHOICE COVERAGE
- ⬭ EMPLOYEE ONLY
- ⬭ EMPLOYEE & SPOUSE
- ⬭ EMPLOYEE & CHILDREN
- ⬭ FAMILY

WAIVER OF COVERAGE
- ⬭ SELF
- ⬭ SPOUSE
- ⬭ DEPENDENT(S)

FOR THOSE EMPLOYEES AND DEPENDENTS DECLINING COVERAGE, SELECT THE APPROPRIATE REASON CODE FROM THE BACK OF THE FORM AND ENTER BELOW.

- ⬭ NEW GROUP
- ⬭ OPEN ENROLLMENT

SECTION I - INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME	LOCATION	GROUP NUMBER	JOB CLASSIFICATION
			⬭ I ⬭ II ⬭ OTHER (SEE EMPLOYER)

SECTION II - INFORMATION REGARDING THE EMPLOYEE

MARK ONE: ⬭ ADD ⬭ CHANGE ⬭ WAIVER — CODE ______ (SEE BACK)

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.

PHYSICAL ADDRESS (NUMBER, STREET & APARTMENT NO.)	CITY	STATE	ZIP + FOUR

MAILING ADDRESS	CITY	STATE	ZIP + FOUR

DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	MARRIED	SINGLE	DATE OF MARRIAGE (MM/DD/YYYY)	HOURS WORKED	DATE OF FULL TIME EMPLOYMENT	WORK TELEPHONE (AREA CODE AND NO.)
	⬭	⬭	⬭	⬭		PER WEEK		

HOME TELEPHONE (AREA CODE AND NO.)	EMAIL ADDRESS	
		See reverse side (I) regarding e-mail authorization.

OTHER COVERAGE INFORMATION:
Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES ⬭ NO ⬭
Do you currently have or have had other coverage within the last 18 months? YES ⬭ NO ⬭ If yes, please complete the other coverage information below.
To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE AND NO.)	CONTRACT HOLDER LAST 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. To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).
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: ⬭ ADD ⬭ DELETE ⬭ CHANGE ⬭ WAIVER — CODE ______ (SEE BACK)

LAST NAME	FIRST NAME	M.I.

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		⬭	⬭	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER LAST NAME	IDENTIFICATION 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: ⬭ ADD ⬭ DELETE ⬭ CHANGE ⬭ WAIVER — CODE ______ (SEE BACK)

LAST NAME	FIRST NAME	M.I.

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		⬭	⬭	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER LAST NAME	IDENTIFICATION 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: ⬭ ADD ⬭ DELETE ⬭ CHANGE ⬭ WAIVER — CODE ______ (SEE BACK)

LAST NAME	FIRST NAME	M.I.

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		⬭	⬭	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	CONTRACT HOLDER LAST NAME	IDENTIFICATION 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

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

PAGE 1 OF ____________ PAGE 2 OF ____________ PAGE 3 OF ____________

Please read the following carefully. Once signed on the reverse, and accepted, this application including all enrollment forms become a part of the BCBSAZ contract with your employer group. If you have any questions concerning this information, please talk with your group's health plan administrator or your BCBSAZ service representative.

ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS

A. I have carefully read the entire application and have been given information that explains the terms and conditions of this coverage. On behalf of myself and the persons listed on this application as eligible dependents, I apply for enrollment and/or waive group benefits subject to all terms and conditions of this coverage offered by my employer. I understand this application includes any enrollment forms I complete when applying for this coverage, including any Risk Evaluation Form. I understand this entire application becomes a part of my group's contract with BCBSAZ.

B. To the best of my knowledge, the information provided with this application is complete and accurate. I understand the information provided with this application is material to BCBSAZ and BCBSAZ will rely on this information to determine my employer group's eligibility for BCBSAZ coverage and/or to establish group premium rates.

C. I understand BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan.

D. I acknowledge and agree 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.

E. If any part of the premium for this coverage is to be met through payroll deduction, I authorize my employer to deduct periodically from my wages and remit to BCBSAZ amounts necessary to continue coverage.

F. I understand the contract between my employer group and BCBSAZ controls the administration of this group coverage. Coverage is subject to change upon notification to my employer group. My employer is responsible for notifying me of all changes, including termination of the employer group contract by (1) the group or (2) BCBSAZ for non-payment of premiums by the group. Upon termination of the employer group contract, I understand I may be eligible for other coverage with BCBSAZ as required under state and/or federal law.

G. I understand that if, BCBSAZ, its reinsurers, and their authorized representatives need to obtain medical information to evaluate my application and/or for claims processing, I am responsible for any costs associated with obtaining such medical information. Personal information may be collected from someone other than me or one of the proposed covered persons.

H. I understand 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 me 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 BCBSAZ plan within 31 days after other coverage ends. In addition, 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, provided that I request enrollment within 31 days after marriage, birth, adoption or placement of adoption. To request special enrollment or obtain more information contact: Group Enrollment Services at (602) 864-4456 or (800) 232-2345, ext. 4456.

I. I understand that BCBSAZ group health plans (except BlueSelect) impose a preexisting condition exclusion. This means that if I have a medical condition before coming to the group plan, I might have to wait a certain period of time before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six month period prior to my enrollment date. For purposes of determining a preexisting condition and a preexisting condition waiting period, enrollment date means my effective date of coverage under the group's health plan or the first day of the group's eligibility waiting period, whichever is earliest. Generally, this six month period ends the day before my coverage under the group plan becomes effective. However, if the group plan imposes an eligibility waiting period for coverage, the six month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the group plan within thirty-one days after birth, adoption or placement for adoption.

   I understand that this exclusion may last up to eleven months (or if my group health plan permits late enrollment, up to eighteen months if I am a late enrollee) from my first day of coverage under this group health plan or the first day of my waiting period. However, I can reduce the length of this exclusion period by the number of days of my prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if I have not experienced a break in coverage of at least sixty-three days. To reduce the eleven month (or eighteen month) exclusion period by my creditable coverage, I can give my group or BCBSAZ a copy of any certificates of creditable coverage that I have. I understand that if I do not have a certificate, but I do have prior health coverage, the group or BCBSAZ will help me obtain one from my prior plan or issuer. There are also other ways that I can show that I have creditable coverage. I can contact the group or BCBSAZ if I need help demonstrating creditable coverage.

   Certain large group health plans may apply a lesser period of review for a pre-existing condition or a different length of exclusion period. If so, a notice of the pre-existing condition waiting period exclusion is enclosed with this application.

   All questions about preexisting condition exclusions and creditable coverage should be directed to Group Enrollment Services at (602) 864-4456 or (800) 232-2345, ext. 4456.

J. 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, AIDS and genetic testing, to BCBSAZ and its representatives. I understand I am responsible for any costs associated with obtaining medical records. BCBSAZ may use this information, and any of my information already in its possession, to evaluate my application, determine eligibility and for claims processing. This information may, in certain circumstances, be disclosed to third parties without my permission if permitted by law.

K. By including my e-mail address on the reverse side, I am authorizing Blue Cross Blue Shield of Arizona (BCBSAZ) to send me information via e-mail. You may change your e-mail address or rescind this permission at any time by contacting BCBSAZ through **azblue.com.**

Reason Codes for Declining/Waiver 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 Co-Workers
H - Individual Coverage