



LARGE GROUP EMPLOYEE APPLICATION

Please check the appropriate box and fill in blanks below in ink.

Group Number:

I.D. Number:

Is the Employee waiving coverage in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete Sections 1, 4 & 7 only.	FOR OFFICE USE ONLY
<input type="checkbox"/> Arkansas Blue Cross and Blue Shield <input type="checkbox"/> Health Advantage—Is this open enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Blue~by~Design HRA <input type="checkbox"/> NOTE: Areas in green apply to Health Advantage only. <input type="checkbox"/> Blue~by~Design HSA <input type="checkbox"/> Life Only (complete Sections 1, 6 & 7)	
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Add a Family Member: <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Newborn — Date of Birth: _____ <input type="checkbox"/> Marriage — Marriage Date: _____ (Submit copy of marriage certificate.)	

Date of Full-Time Employment Mo Day Year	COBRA Effective Date Mo Day Year	COBRA Termination Date Mo Day Year	Reason for COBRA: _____
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SECTION 1. EMPLOYEE INFORMATION

First Name	Middle Name	Last Name	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Home Address		City	State Zip Code
Home Phone No.	Work Phone No.	Employer	Job Title
Coverage Desired: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee, Spouse & Child(ren)	Employment Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Other	Hours Worked Weekly _____	
Are you a current, active employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, retirement date: _____			

SECTION 2. (Complete this section on all members to be covered)

Social Security Number	First Name	M. I.	Last Name	County of Residence	Birth Date Mo/Day/Yr	Sex M or F	Height/Weight	\$ Amt Deductible Credit Applied (ABCBS Only)	Primary Care Physician	PCP Number (5-digit)	Was This Your Regular Physician?
Employee _____-_____-_____							Ht. _____ Wt. _____				Yes / No
Spouse _____-_____-_____							Ht. _____ Wt. _____				Yes / No
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____				Yes / No
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____				Yes / No
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____				Yes / No
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. _____-_____-_____							Ht. _____ Wt. _____				Yes / No

College Student's Name	Name of Accredited School/College at which dependent is a full-time student	City	State
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Do all dependents listed above reside at the same address as employee? Yes No
 If NO, list dependent(s) name and address: _____

SECTION 3. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)
 Will you, your spouse or dependents be continuing any other health insurance coverage, including Medicare? Yes No
If you answered Yes, complete Part 1 and/or Part 2 as applicable – (Use additional paper if necessary)

Part 1: If continuing coverage is Medicare, complete the following: Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:	Relationship of Beneficiary to Policyholder:
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Medicare Health Identification Contract (HIC) Number: _____

Type of Medicare Coverage (check all that apply)

Medicare Part A – Effective Date: _____ Medicare Part B – Effective Date: _____

Part 2: If continuing coverage is other than Medicare, complete the following – (If covered by more than one insurance plan, use additional paper)

Name of Insurance:	Address:	Phone:
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Policyholder Name:	Date of Birth:	
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Member ID#:	FOR OFFICE USE ONLY
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List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)	C/T	PKG	WWP
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First Name	Last Name	Relationship	✓	Effective Date of Coverage	Eff Date	IMP
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Life	AD&D
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Timely _____	UND	Date
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Late _____	OTHER
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For members listed above, are you responsible for providing primary health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No – Please name responsible party:	
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* Deductible Credit only given on initial application for coverage with Arkansas Blue Cross (not applicable to Health Advantage).

Name:

SECTION 4. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

Please list individual(s), including yourself, if applicable, for whom you did not apply for coverage. Indicate whether the named individual(s) have coverage with another group plan or other insurance:

Table with 4 columns: Name, Dependency Relationship, Other Coverage (Yes/No), Name of Health Insurance Co.

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan.

SECTION 5. CREDITABLE COVERAGE INFORMATION

If the insurance or HMO coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part or all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request.

Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? Yes No

If YES, please provide the coverage history for the past 18 months in the spaces below.

Table with 5 columns: Name of Persons Covered, Name, Address, Phone No. & Policy No. of Prior Health Insurance Co., Effective Date, Termination Date, Reason for Termination

SECTION 6. LIFE INSURANCE

USABLE Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USABLE Life does not sell or service Arkansas Blue Cross and Blue Shield products. USABLE Life is solely responsible for life insurance.

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

Table with 5 columns: First Name, M.I., Last Name, Date of Birth, Relationship

SECTION 7. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield, Health Advantage and USABLE Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date. I understand that in addition to other exclusions and limitations provided in the Arkansas Blue Cross and Blue Shield, Health Advantage and USABLE Life group policies, NO BENEFITS WILL BE AVAILABLE DURING THE APPLICABLE PRE-EXISTING CONDITION EXCLUSION PERIOD FOR TREATMENT OF ANY CONDITION FOR WHICH A COVERED PERSON RECEIVED MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WITHIN THE SIX (6) MONTH PERIOD ENDING ON THE EFFECTIVE DATE OR THE FIRST DAY OF THE WAITING PERIOD, WHICHEVER IS EARLIER.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield, Health Advantage or USABLE Life may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield, Health Advantage or USABLE Life may take legal action at any time.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature lines for Applicant and Employer/Group Representative, including fields for Print Name, Signature, and Date.

*Required for new hires and additions only.