BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460
Little Rock, Arkansas 72203-1460

ENROLLMENT FORM

EMPLOYMENT AND COVERAGE INFORMATION

NAME OF EMPLOYER	GROUP #	TYPE OF COVERAGE	BENEFIT PLAN SELECTED	EFFECTIVE DATE	IS THIS A LATE ENROLLMENT*
NWACC	020106	☐ SINGLE MEDICAL ☐ FAMILY MEDICAL ☐ OTHER_____			

EMPLOYEE INFORMATION

FOR EMPLOYER USE ONLY

LAST NAME	FIRST NAME	M.I.	BIRTH DATE MO.	BIRTH DATE DAY	BIRTH DATE YR.	SEX M/F	DATE OF HIRE MO.	DATE OF HIRE DAY	DATE OF HIRE YR.	SOCIAL SECURITY NUMBER	SELECTED PCN PHYSICIAN*	PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE

CURRENT MAILING ADDRESS

STREET OR P.O. BOX	CITY	STATE	ZIP CODE	COUNTY

COMPLETE FOR FAMILY COVERAGES ONLY:

EMPLOYEE AND SPOUSE ☐ EMPLOYEE AND CHILDREN ☐ EMPLOYEE AND FAMILY ☐

FOR EMPLOYER USE ONLY

LAST NAME	FIRST NAME	M.I.	DEPENDENT SOCIAL SECURITY NO.	BIRTH DATE MO.	BIRTH DATE DAY	BIRTH DATE YR.	SEX M/F	RELATIONSHIP TO EMPLOYEE	**FULL-TIME STUDENT	HANDI-CAPPED	SELECTED PCN PHYSICIAN*	PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE

OTHER INSURANCE INFORMATION

Spouse's Employer:
Spouse's Date of Birth:

Do you or any member of your family have other health ☐ Yes ☐ No ☐ Medicare ☐ Blue Cross/Blue Shield
If Medicare, reason for coverage: ☐ Over 65 ☐ Disabled ☐ Kidney Disease Medicare effective date:_____

If yes, please indicate: Policy Holder_____ Policy #_____
Insurance Co. Name_____
Insurance Co. Address_____

Type of Coverage: ☒ **Medical**
☐ Single
☐ Family

IMPORTANT: ALL APPLICATIONS MUST BE SIGNED

PLEASE SIGN BELOW:
I hereby authorize any providers of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original. I also release to BlueAdvantage Administrators of Arkansas any and all information relative to Title XVIII Medical Claims, or claims with other benefit plans or insurance companies, by or on behalf of me or any covered member of my family, in order to coordinate benefits with this plan.

If you are enrolling in a PCN program:
I have read and understand the material provided explaining The Primary Care Network and have elected to enroll in this program. I understand that no PCN services (except life threatening or unless otherwise specified by your plan document) will be covered without being authorized by the Primary Care Physician listed on this application for myself and any eligible family members. I further recognize that I have the right to voluntarily change primary care physicians participating in The Primary Care Network without losing the additional benefits available under this program. I understand that should I, or a family member covered under my contract, fail to adhere to the provisions of the Primary Care Network Program, I could be forced to return to the standard benefits program offered through my employer or be forced to encounter additional out-of-pocket expense due to reduced benefit payment.

I further authorize payment direct to my primary care physician, referred physician, hospital or other medical provider for the medical benefits otherwise payable to me.

I understand that all determinations affecting the quality of medical care will be solely between myself and my physicians.

EMPLOYEE SIGNATURE_____ EMPLOYER SIGNATURE_____ *ENROLLMENT DATE_____

BAAA53-01 ☐ I understand that checking this box constitutes a legal signature