BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYEE APPLICATION

BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE
- ◯ BLUEPREFERRED (PPO)
- ◯ BLUEPREFERRED SAVER (PPO)
- ◯ BLUEPREFERRED BASIC (PPO)
- ◯ BLUESOLUTIONS (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 BOTTOM OF PAGE 3 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 May be required. See (N) on page 3.	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 PER WEEK	DATE OF FULL TIME EMPLOYMENT	WORK TELEPHONE (AREA CODE AND NO.)
	◯	◯	◯	◯				

HOME TELEPHONE (AREA CODE AND NO.)	EMAIL ADDRESS	
		See page 3 (M) 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.)	POLICY 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 May be required. See (N) on page 3	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		◯	◯	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY 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 May be required. See (N) on page 3	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		◯	◯	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY 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 May be required. See (N) on page 3	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		◯	◯	

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY 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

PAGE 1 OF _____ PAGE 2 OF _____ PAGE 3 OF _____

Select your Life, Short Term Disability, and Long Term Disability Coverage available from USAble Life:

USAble Life is an independent company, is not affiliated in any way with BCBSAZ, and does not provide BCBSAZ products or services. USAble Life's policies are not underwritten by BCBSAZ, and BCBSAZ is not responsible for any products or services offered by USAble Life.

- ☐ **USAble Life Basic Life / Accidental Death & Dismemberment (AD&D)**
- ☐ **USAble Life Dependent Life *(available only if you elect Basic Life / AD&D)***
- ☐ **USAble Life Short Term Disability**
- ☐ **USAble Life Long Term Disability**

If I select this coverage, I: (1) Acknowledge and agree that if I am not actively at work on the effective date of my coverage, my insurance provided by USAble Life will not begin until the day I return to work; (2) Designate the individuals named below as beneficiaries under this certificate and revoke the appointment of any existing beneficiary; (3) Understand this application becomes part of my group's contract with USAble Life.

Salary: $ _____ per _____ | Life Class: _____ | _____ | _____ | Job Title: _____

Beneficiary Designation / Change

This will revoke any existing beneficiary designations you may have for these benefits. ☐ check if change only

Primary Beneficiary(ies)

Will receive proceeds if living at death of Employee.

NAME (LAST, FIRST, M.I.)		ADDRESS	
SOCIAL SECURITY NUMBER	**BIRTH DATE**	**RELATIONSHIP**	**PERCENTAGE**
NAME (LAST, FIRST, M.I.)		**ADDRESS**	
SOCIAL SECURITY NUMBER	**BIRTH DATE**	**RELATIONSHIP**	**PERCENTAGE**

Total percentage (must equal 100%) = _____

Contingent Beneficiary(ies)

Will receive proceeds if Primary Beneficiary(ies) are not living.

NAME (LAST, FIRST, M.I.)		ADDRESS	
SOCIAL SECURITY NUMBER	**BIRTH DATE**	**RELATIONSHIP**	**PERCENTAGE**
NAME (LAST, FIRST, M.I.)		**ADDRESS**	
SOCIAL SECURITY NUMBER	**BIRTH DATE**	**RELATIONSHIP**	**PERCENTAGE**

Total percentage (must equal 100%) = _____

ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS APPLICABLE TO HEALTH INSURANCE COVERAGE THROUGH BCBSAZ

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

A. I have carefully read this entire 3 page application form and have been given information that explains the terms and conditions of the available health insurance coverage.

B. This application includes any enrollment forms I complete when applying for this coverage, including any Risk Evaluation Form. This application, excluding the provisions related to life and disability coverage, becomes a part of my group's contract with BCBSAZ.

C. The information I have provided on 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.

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

E. 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.

F. 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 for any reason.

G. If the employer group contract is terminated, I may be eligible for other coverage with BCBSAZ as required under state and/or federal law.

H. If, BCBSAZ, its reinsurers, or their respective authorized representatives need to obtain medical information to evaluate my application or to process claims, 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. 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, its reinsurers, and their respective authorized representatives. BCBSAZ may use this information, and any of my information already in its possession, to evaluate my application, determine eligibility, and process claims. When permitted by law BCBSAZ may disclose this information to third parties without my permission.

I. 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.

J. If I have a new dependent as a result of marriage, birth, adoption or placement of adoption, I may be able to enroll my self and/or my dependents, if 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.)

K. BCBSAZ group health plans (except BlueSelect) impose a preexisting condition exclusion period. 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 cover 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 before my enrollment date. To determine 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 preexisting 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" if I have not experienced a break in coverage of more than sixty-three days. To reduce the applicable exclusion period by my creditable coverage, I can give my group or BCBSAZ a copy of any certificates of creditable coverage that I have. If I do not have a certificate, but do have prior health coverage, the group or BCBSAZ will help me obtain one from my prior plan or issuer or help me prove my creditable coverage some other way. I can contact the group or BCBSAZ if I need help showing creditable coverage.

   Some large group health plans may have a shorter or longer period of review for a preexisting condition or preexisting exclusion period. If so, a notice of the non-standard time period 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.

L. I understand I am responsible for any costs associated with obtaining medical records.

M. By including my e-mail address on page 1, I authorize BCBSAZ to send me information via e-mail. I can change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.

N. Federal statute requires BCBSAZ to obtain the Social Security number (SSN) for members in the following categories:

   1. Non-retired employees age 45 or older, and their spouses and dependents age 45 or older **(for age-in purposes, BCBSAZ requires a SSN for age 44 and older)**.

   2. Those covered by Medicare due to disability or end-stage renal disease.

   3. Applicants who have a dependent in either of the categories above (even if the applicant is not in either category).

   BCBSAZ will not enroll any individual who is required to provide an SSN and fails to do so.

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

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 3-page form; (2) I understand and agree to its terms; (3) I apply for enrollment and/or waive group benefits as indicated on pages 1 and 2 of 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 that provision of false information may result in fines and criminal penalties; and (5) if any part of any premium for coverage will be paid through payroll deduction, I authorize my employer to periodically deduct from my wages, and remit to the applicable insurer, amounts necessary to continue coverage.

X _____

EMPLOYEE'S SIGNATURE DATE

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

azblue.com

An Independent Licensee of the Blue Cross and Blue Shield Association

08-1968