

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI) _____ 2. Birthdate ____/____/____ 3. Male Female
 4. Address: (Street) _____ (City) _____ (State) _____ (Zip) _____
 5. Employee Social Security Number: _____ - _____ - _____ 6. Home Phone (____) _____ - _____ Email: _____
 7. Name of Employer: _____ 8. Group No.: _____
 9. Dept. No.: _____ 10. Effective Date of Action Requested: ____/____/____

REASON FOR APPLICATION

11. New Member – I am a full-time employee working at least 30 hours per week, 48 weeks per year? Yes No Full-time Date of Hire: ____/____/____
 Coverage Change – Reason for Change: _____ Date of Occurrence: _____
 Late Enrollee Address Change Beneficiary Change Cancellation – Date Left Employment: ____/____/____
 Reinstatement – Reason: Return from Layoff Return from Leave Cancellation Error
 COBRA Qualifying Event: _____ Start Date: ____/____/____
 State Continuation – Start Date: ____/____/____
 Sponsored Membership – Sponsored Member's Social Security Number: _____ - _____ - _____

COVERAGE INFORMATION

<p>12. MEDICAL ELECTION (Check One) <input type="checkbox"/> PPO <input type="checkbox"/> HDHP</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Medical Coverage due to: (Check one) <input type="checkbox"/> Other BCBS of SC Coverage (01) <input type="checkbox"/> Covered by Military (03) <input type="checkbox"/> Insurance with Another Company (02) <input type="checkbox"/> Covered by Medicare (12) <input type="checkbox"/> Covered by Spouse with this Employer (07) <input type="checkbox"/> Other (05) (explain) _____</p>	<p>13. DENTAL ELECTION</p> <p><input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Dental Coverage</p>	<p>14. LIFE COVERAGE</p> <p><input type="checkbox"/> Life Only (No Medical) <input type="checkbox"/> Life and AD&D Life Amount \$ _____ <input type="checkbox"/> Dependent Life Life Class _____ <input type="checkbox"/> STD <input type="checkbox"/> LTD Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually</p>
<p>Beneficiary: Primary: _____ Relationship: _____ Contingent: _____ Relationship: _____</p>		

ENROLLMENT INFORMATION (List all individuals to be covered.)

15.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Full-Time Student*
Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No

(*Age 19 through 22 Only) Please attach Registrar's letter or tuition receipt showing credit hours. This is required before coverage can become effective for this dependent.)

OTHER COVERAGE INFORMATION

16. Other than your coverage with this employer, do you or any of your family members have other health (including Medicare), dental or drug coverage?
 Yes No

If yes and the policy is with Blue Cross and Blue Shield of South Carolina, please indicate the Policyholder's ID Number: _____

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*

I hereby authorize the release of any medical or non-medical information about myself or eligible or enrolled dependents by any insurance company, medical professional, medical institution or other healthcare provider concerning the diagnosis, the treatment, and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations have been made on this application. I certify that all statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for twelve months then subject to pre-existing conditions for six months.

Signature _____ Date _____