Event change-Other than OE

EMPLOYEE APPLICATION

EFFECTIVE DATE OF COVERAGE:

BCBSAZ ID NUMBER (existing member)
Not Applicable

EMPLOYEE NUMBER (employer use only)
BCBSAZ Retiree

MEDICAL PLAN TYPE
- (✓) PPO
- ( ) PPO HSA QUALIFIED
- ( ) HMO
- ( ) OTHER
- ( ) BLUEALLIANCE*

OPTION

DENTAL
- ( ) DENTAL

N/A
OPTION

*MOST IN-NETWORK ARIZONA PROVIDERS FOR THIS LOCAL NETWORK PLAN ARE LOCATED ONLY IN MARICOPA COUNTY.

MEDICAL COVERAGE
- ( ) EMPLOYEE ONLY
- ( ) EMPLOYEE & SPOUSE
- ( ) EMPLOYEE & CHILDREN
- ( ) FAMILY

DENTAL COVERAGE
- ( ) EMPLOYEE ONLY
- ( ) EMPLOYEE & SPOUSE
- ( ) EMPLOYEE & CHILDREN
- ( ) FAMILY

ARE YOU DECLINING COVERAGE FOR:

SELF?	( ) Y	( ) N
SPOUSE?	( ) Y	( ) N
DEPENDENT(S)?	( ) Y	( ) N

If yes, include the appropriate reason code(s) in Section II below. (A list of reason codes is found near the bottom of page 2.)

- ( ) NEW GROUP
- ( ) Event Change

OPT FOR A FLEXIBLE SPENDING ACCOUNT (FSA) AVAILABLE FROM HEALTH EQUITY

( ) I want a healthcare FSA ( ) I want a dependent care FSA ( ) I do not want an FSA ----NOT APPLICABLE----

SECTION I – INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME	LOCATION	GROUP NUMBER	JOB CLASSIFICATION
BCBSAZ – Retiree		50	( ) I ( ) II ( ) OTHER (SEE EMPLOYER)

SECTION II – INFORMATION REGARDING THE EMPLOYEE

MARK ONE: ( ) ADD ( ) CHANGE ( ) WAIVER CODE_____(SEE BACK)

SOCIAL SECURITY NUMBER Required. See (O) on page 2.	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)	WORK TELEPHONE (AREA CODE AND NO.)	HOME TELEPHONE (AREA CODE AND NO.)
	( )	( )	( )	( )			

EMAIL ADDRESS	See page 2 (N) regarding e-mail authorization

OTHER COVERAGE INFORMATION: Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES ( ) NO ( )
If yes, please complete the other coverage information below.

OTHER HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME	ID/SOCIAL SECURITY NUMBER

GROUP/POLICY NO.	EFFECTIVE 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.
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 Required. See (O) on page 2	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		( )	( )	

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

GROUP/POLICY NO.	EFFECTIVE 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 Required. See (O) on page 2	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		( )	( )	

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

GROUP/POLICY NO.	EFFECTIVE 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 Required. See (O) on page 2	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	RELATIONSHIP
		( )	( )	

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

GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	MEDICARE CARD NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

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

X _____
EMPLOYEE'S SIGNATURE DATE

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS APPLICABLE TO EMPLOYMENT-BASED HEALTH BENEFIT PLAN COVERAGE OFFERED BY OR ADMINISTERED THROUGH BLUE CROSS BLUE SHIELD OF ARIZONA (BCBSAZ), an independent licensee of the Blue Cross Blue Shield Association

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

A. I have received information summarizing the terms and conditions of the health coverage available through my employment ("Coverage"). The Coverage is either (a) group health insurance that my employer has purchased from BCBSAZ; or (b) a group benefit plan, for which BCBSAZ provides certain administrative, claims payment, and utilization management services, and provider network access, but does not assume financial risk or obligation for claims.

B. I have carefully reviewed this entire application form and the answers I've provided. My answers are material to BCBSAZ. BCBSAZ will rely on my information to determine my employer group's eligibility for BCBSAZ coverage or administrative services, and to establish premium rates or administrative fees for my employer group.

C. My application includes any other enrollment forms I complete when applying for this coverage. This completed application becomes a part of my group's contract with BCBSAZ, except for any provisions related to life and disability coverage or separate financial accounts (HSA, FSA, HRA).

D. BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan. BCBSAZ is independent from any companies that offer such coverage.

E. BCBSAZ does not administer or guarantee any separate financial account or arrangement (HSA, HRA, FSA) that may be part of the group benefit plan sponsored by my employer. BCBSAZ is independent from any companies that administer such coverage or accounts.

F. 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 in accordance with the employer's terms for coverage.

G. The contract between my employer group and BCBSAZ controls the administration of this group coverage. The Coverage is subject to change, as permitted under applicable state and federal law, and in accordance with the terms of the contract between my employer and BCBSAZ. My employer is responsible for notifying me of all changes, including termination of the employer group contract for any reason.

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

I. BCBSAZ, its reinsurers, or their respective authorized representatives may need to obtain medical information to process claims, and may collect personal information 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, and AIDS (but not genetic testing or family history), to BCBSAZ, its reinsurers, and their respective authorized representatives. BCBSAZ may use this information, and any of my information already in its possession to process claims. When permitted by law BCBSAZ may disclose this information to third parties without my permission.

J. 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 myself 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 Coverage within 30 days after other coverage ends. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet.

K. 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, if I request enrollment within 31 days (60 days for small groups*) after marriage, birth, adoption or placement of adoption. For a complete list of special enrollment events, please refer to your Benefit Plan Booklet. (To request special enrollment or obtain more information contact: Group Enrollment Services at (602) 864-4456 or (800) 232-2345, ext. 4456.)

L. Information regarding other health plan coverage is not used to determine pre-existing conditions for BCBSAZ plans beginning or renewing on or after January 1, 2014.

M. I am responsible for any costs associated with obtaining medical records needed to process claims.

N. By including my e-mail address on this form, 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.

O. Federal statute and BCBSAZ business processes require BCBSAZ or my employer plan sponsor to obtain the Social Security number (SSN) for most applicants.

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 purchased directly from carrier
I - Individual coverage purchased on Healthcare Marketplace

*Employers are considered small groups for purposes of the Affordable Care Act (ACA) if the average number of total employees on business days during the previous calendar year is 50 or fewer.

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