



EMPLOYEE APPLICATION (2-100)

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

GROUP ADMINISTRATOR USE ONLY

Group No.:

I.D. No.:

Class:

Is the Employee waiving coverage in the plan? Yes No If yes, complete Sections 1, 3 & 8 only.

FOR OFFICE USE ONLY

Arkansas Blue Cross and Blue Shield *Health Advantage – Is this open enrollment?* Yes No

Life Only (complete Sections 1, 2, 3, 5 & 8) **NOTE: Areas in green italic apply to Health Advantage only.**

New Enrollee

Add a Family Member:

Loss of Other Coverage

Newborn — Date of Birth: _____

Marriage — Marriage Date: _____

(Submit copy of marriage certificate.)

Date of Full-Time Employment

COBRA Effective Date

COBRA Termination Date

Reason for COBRA:

Mo Day Year

Mo Day Year

Mo Day Year

SECTION 1. EMPLOYEE INFORMATION

First Name

Middle Name

Last Name

Marital Status: Married Single
 Divorced Widowed

Home Address

City

State

Zip Code

Home Phone No.

Work Phone No.

Employer

Job Title

Coverage Employee Only Employee & Child(ren)
Desired: Employee & Spouse Employee, Spouse & Child(ren)

Employment Hourly Hours Worked Weekly _____
Status: Salaried Other

SECTION 2. (Complete this section on all members to be covered. The last three columns only apply to Health Advantage applicants.)

Social Security Number	First Name	M. I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F	Height/Weight	\$ Amt/Yrs. Deductible Credit Submitted*	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
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College Student's Name

Name of Accredited School/College at which dependent is a full-time student

City

State

Do all dependents listed above reside at the same address as employee? Yes No
If NO, list dependent(s) name and address:

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SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS

To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Medical Coverage Declined For:

Myself

Spouse

Dependents

Covered by spouse's group coverage – Carrier Name and ID:

Enrolled in other Insurance Carrier Plans – Carrier Name and ID:

Medicare

Covered by TRICARE or CHAMPVA

Other (Explain):

C/T

PKG

WWP

Eff Date

IMP

Life

AD&D

Timely ____

UND

Date

Late ____

OTHER

* Deductible Credit is available for new group enrollments with Arkansas Blue Cross (Not Health Advantage) but only if the individual requests it on this initial application.

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS (continued)

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. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 4. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Yes **No** On the day coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage? If yes, answer all questions below. (Use additional paper if necessary)

Yes **No** Is the continuing coverage Medicare? If so, complete the following:
Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:

Medicare Health Identification Contract (HIC) Number:

Relationship of Beneficiary to Policyholder:

Type of Medicare Coverage (check all that apply) Medicare Part A – Effective Date: _____ Medicare Part B – Effective Date: _____

Yes **No** Is the continuing coverage other than Medicare? If so, complete the following: (if covered by more than one insurance plan, use additional paper)

Name of Insurer	Address	Phone
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Policyholder Name	Date of Birth	Member ID #
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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)

First Name	Last Name	Relationship	✓	Effective Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? Yes No – Please name responsible party: _____

SECTION 5. LIFE INSURANCE (Issued by USABLE Life for any employer with 2-50 employees)

USABLE Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield and Health Advantage. USABLE Life does not sell or service Arkansas Blue Cross and Blue Shield or Health Advantage 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.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 6. PROOF OF PRIOR COVERAGE

Yes **No** Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

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. If, for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e., explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

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

SECTION 7. MEDICAL QUESTIONNAIRE

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH CONDITIONS.** However, **FAILURE TO REVEAL ALL MEDICAL INFORMATION WHETHER INTENTIONAL OR UNINTENTIONAL MAY RESULT IN TERMINATION OR RESCISSION OF COVERAGE.**

1. **Yes** **No** Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? If "Yes", Member: _____ Reason: _____
2. **Yes** **No** Has any person to be insured ever been insured with Arkansas Blue Cross and Blue Shield or Health Advantage? If "Yes", Member: _____
3. **Yes** **No** Has any person to be insured used tobacco in the last 12 months? If "Yes", Member: _____ What type? _____

In the past 10 years, has any person to be insured ever been diagnosed or been advised to have treatment or care for any of the following conditions? **Check the appropriate box(es) below and explain in Additional Medical Information section.**

<table border="0" style="width: 100%;"> <tr> <td style="width: 5%;">Y</td> <td style="width: 5%;">N</td> <td style="width: 90%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4. Heart Condition</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5. Circulatory Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6. Pancreatic Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>7. Lung Problem</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>8. COPD or Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>9. Brain Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>10. Mental Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>11. 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32. **Yes** **No** In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? (If "Yes", give details in the additional medical Information Section below.)

33. **Yes** **No** In the past 10 years, has any person to be insured ever seen, or been advised to see a health care provider, surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, endocrinologist? (Circle each provider and give details in the Additional Medical Information Section below.)

ADDITIONAL MEDICAL INFORMATION List below full details to questions answered "Yes." (Additional space available on the next page.)

Question Number	Person Treated	Condition & Type of Treatment	Date Occurred	Last Date of Treatment	Current Status	Complete Name and Address of Physician

34. **Yes** **No** In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? If "yes", list full details below. (Additional spaces available on the next page.)

35. **Yes** **No** Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Additional space available on the next page.)

PRESCRIPTION INFORMATION

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name & Address of Physician

