

GROUP EMPLOYEE APPLICATION

Please print clearly and complete the entire form in ink.

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

Arkansas Blue Cross and Blue Shield Health Advantage

Group No. _____ **Employer** _____ **ID No.** _____

**Group Administrator
Use Only**
Multi-option: which

Is the employee waiving coverage in the plan? Yes No If yes, complete Sections 2, 6 and 9 only.

FOR OFFICE USE ONLY

Date of Full-Time Employment

COBRA Effective Date

COBRA Termination

Reason for COBRA:

Mo	Day	Year

Mo	Day	Year

Mo	Day	Year

Are you a current, active employee? Yes No If no, retirement date: _____

SECTION 1 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

- | | | | | |
|---|-------------|--|-------------|-------|
| <input type="checkbox"/> 1—Annual Open Enrollment Period | Date | _____ | Date | _____ |
| <input type="checkbox"/> 2—New Hire | | | | |
| <input type="checkbox"/> 3—New Enrollee-Life Only
(Omit Section 7) | | | | |
| <input type="checkbox"/> 4—Loss of Minimum Essential Coverage | _____ | <input type="checkbox"/> 6—Marriage | _____ | |
| <input type="checkbox"/> 5—Newborn | _____ | <input type="checkbox"/> 7—New Adoption | _____ | |
| | | <input type="checkbox"/> 8—New Guardianship/Legal Custody/Court Order to Add Child | _____ | |
| | | <input type="checkbox"/> 9—Other Reason: Ex. Rehire, ACA (give specific reason) | _____ | |

NOTE: If application is **not** received during Open Enrollment Period, we must receive appropriate documentation with this Application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.).

SECTION 2 | WHO IS APPLYING

Complete this section on all members to be covered or waived.

NOTE: Dependents of **small groups** are not required to complete this section if waiving coverage.

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

Please indicate under the relationship column below whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.	Waiving (✓)	\$Amt Deductible Credit Submitted	Primary Care Physician	PCP Number (NPI#)
			Self							

*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 | MARITAL STATUS

Single (including widowed or divorced) Married (including separated)

SECTION 4 | CONTACT INFORMATION

Street or P.O. Box _____ City _____ State _____ ZIP _____

Primary Phone Number () _____ Work Phone Number () _____ Email _____

SECTION 5 | EMPLOYMENT STATUS

FOR OFFICE USE ONLY

Job Title _____	Tax ID* (EIN) _____	C/T	PKG	LIFE
*For 1095 Reporting		EFF DATE	UND	DATE
<input type="checkbox"/> Hourly Hours Worked Weekly _____	<input type="checkbox"/> Salaried	<input type="checkbox"/> Other _____		
OTH				

SECTION 6 | WAIVER OF ENROLLMENT

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

Medical Coverage Declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	<input type="checkbox"/> Covered by spouse's group coverage – Carrier Name and ID:		
	<input type="checkbox"/> Enrolled in other insurance carrier plans – Carrier Name and ID:		
	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Covered by TRICARE or CHAMPVA
	Other (Explain):		

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 will be deferred until open enrollment.

SECTION 7 | CURRENT/PREVIOUS INSURANCE INFORMATION

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

For previous or continuing coverage please complete the following:
(If covered by more than one insurance plan, use additional paper)

Insurance Company	Address	Phone
Policyholder Name	Date of Birth	Member ID#

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	<input checked="" type="checkbox"/>	Eff. Date of Coverage	End Date of Coverage

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

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

Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name: _____ Relationship of Beneficiary to Policyholder: _____

Medicare Health Identification Contract (HIC) Number: _____

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

SECTION 8 | LIFE INSURANCE (Issued by USABLE Life if purchased by your employer)

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 9 | SIGNATURES (Please read before signing)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield, Health Advantage and USABLE Life group policies with my employer and may from time to time be amended. I understand that coverage will not become effective before the approved effective date.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield, Health Advantage or USABLE Life may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield, Health Advantage or USABLE Life may take legal action at any time.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____	_____	_____
Print Name of Applicant (Employee)	Signature of Applicant (Employee)	Date
_____	_____	_____
Print Name of Employer/Group Representative*	Signature of Employer/Group Representative*	Date

**Required for new hires and additions only.*

