BlueCross BlueShield of Alabama

Application for Enrollment

PLEASE PRINT CLEARLY AND BE SURE TO SIGN AND DATE THIS FORM

EMPLOYEE INFORMATION – PLEASE PRINT

LAST NAME:	FIRST NAME:			DATE OF BIRTH:
STREET ADDRESS:	CITY:	STATE:	ZIP:	PHONE #:
CHECK ONE: ☐ MALE ☐ FEMALE	CHECK ONE: ☐ SINGLE ☐ MARRIED	EMPLOYEE SOCIAL SECURITY NUMBER:	EMPLOYEE (J) # J	**TYPE COVERAGE:** ☐ INDIVIDUAL ☐ FAMILY

SELECT YOUR PLAN– CHECK ONE

☐ I am applying for coverage in the **USA Choice Plan**. (Group 78380)

☐ I am applying for coverage in the **USA Select Plan**. (Group 67307)

NATURE OF THE APPLICATION – CHECK THE APPROPRIATE BOX FOR THE ACTION DESIRED

	CHANGE CONTRACT:	ADD/REMOVE DEPENDENT:	
☐ NEW CONTRACT APPLICATION	☐ NAME CHANGE/ADDRESS CHANGE	☐ ADD SPOUSE	☐ REMOVE SPOUSE
☐ CANCEL CONTRACT	☐ TYPE COVERAGE CHANGE	☐ ADD CHILD	☐ REMOVE CHILD

DATE EVENT OCCURRED (EXAMPLE: DATE OF MARRIAGE, BIRTH DATE OF CHILD, DATE OF DEATH, ETC.): ____________________

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER AND/OR ITIN NUMBER

The Social Security Number for the employee and ALL dependents must be provided in order for this application to be processed.

LAST NAME	FIRST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER AND/OR ITIN NUMBER	DATE OF BIRTH MONTH	DAY	YEAR
		SPOUSE ☐ MALE ☐ FEMALE				
		☐ SON ☐ DAUGHTER				
		☐ SON ☐ DAUGHTER				
		☐ SON ☐ DAUGHTER				
		☐ SON ☐ DAUGHTER				

EMPLOYEE CERTIFICATION

TOBACCO USE CERTIFICATION:

The USA Health & Dental Plans are committed to helping you achieve your best health. The Wellness Incentive is available to all employees. If you think you might be unable to meet the standard under this Wellness Program, you may qualify for an opportunity to earn the same reward by different means. Contact the USA Human Resources department for additional information.

HAVE YOU OR YOUR SPOUSE USED TOBACCO PRODUCTS WITHIN THE LAST SIX (6) MONTHS?: ☐ **YES** ☐ **NO**

I understand that my application is subject to the terms and conditions of the Plan and that coverage is subject to the eligibility rules and plan of benefits as stated in the Summary Plan Description (SPD). I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law. I understand that coverage under the Plan will not become effective until my application is accepted by evidence of issuing an identification card or other written notice. I agree to notify the USA Human Resources department if an eligible dependent has a change-in-status, especially if a dependent is no longer a dependent due to divorce. I authorize my doctor, hospital or anyone else to give all medical records for anyone covered under my coverage to the claims administrator for the operation of the Plan including determination of eligibility and benefits. I agree to cooperate with the claims administrator and provide information required to administer the Plan, pay claims, coordinate benefits with other coverage, subrogate against another responsible party or recover benefits paid in error. I agree that benefits may be paid directly to providers of service and such payment will release the Plan of its benefit obligation.

Premiums are paid one-month in advance. Based on the date of your enrollment application, retroactive premium payments may be required to start your coverage. Further, I attest that everything in the application is true.

______________________________ Signature of Employee

______________________________ Date Signed

STOP – TO BE COMPLETED BY UNIVERSITY OF SOUTH ALABAMA HR DEPARTMENT REPRESENTATIVE

All the information appears to be complete and correct.

☐ USA ☐ HCM ☐ HCA ______________________________ Signature of HR Representative ______________ Date