Application

For Enrollment without Binding Arbitration

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

ENR1-2001

BlueCross BlueShield of Alabama

Application For Enrollment

Fields marked with an *are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

*HEALTH GROUP NUMBER	*HEALTH DIVISION NUMBER	*DENTAL GROUP NUMBER	*DENTAL DIVISION NUMBER

***NATURE OF APPLICATION** *(Check all that apply)*

☐ NEW CONTRACT	☐ CANCEL CONTRACT	☐ CHANGE CONTRACT
☐ HEALTH ☐ DENTAL	☐ HEALTH ☐ DENTAL	☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ TYPE COVERAGE CHANGE

ENROLLMENT PERIOD *(for new contracts)*

REGULAR ENROLLMENT ANNUAL OPEN ENROLLMENT SPECIAL OPEN ENROLLMENT

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER

*HOME MAILING ADDRESS

*CITY	*STATE	*ZIP

*PHONE NUMBER ○ HOME ○ WORK ○ CELL	E-MAIL ADDRESS (Optional)

*GENDER ○ MALE ○ FEMALE	*DATE OF BIRTH (MM/DD/YYYY)

*EMPLOYEE NUMBER	

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER

*RELATIONSHIP ○ CHILD ○ SPOUSE ○ OTHER	*GENDER ○ MALE ○ FEMALE	*DATE OF BIRTH (MM/DD/YYYY)

☐ ADD DEPENDENT	QUALIFYING EVENT TYPE: ○ Marriage ○ Birth/Adoption ○ Loss of Coverage ○ Other	* DATE EVENT OCCURRED

☐ REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: ○ Divorce ○ Death ○ Entered Military Service ○ Request	* DATE EVENT OCCURRED

○ ADD HEALTH ○ ADD DENTAL ○ ADD BOTH	○ REMOVE HEALTH ○ REMOVE DENTAL ○ REMOVE BOTH

DEPENDENT

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER

*RELATIONSHIP ○ CHILD ○ OTHER	*GENDER ○ MALE ○ FEMALE	*DATE OF BIRTH (MM/DD/YYYY)

☐ ADD DEPENDENT	QUALIFYING EVENT TYPE: ○ Marriage ○ Birth/Adoption ○ Loss of Coverage ○ Other	* DATE EVENT OCCURRED

☐ REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: ○ Divorce ○ Death ○ Entered Military Service ○ Request	* DATE EVENT OCCURRED

○ ADD HEALTH ○ ADD DENTAL ○ ADD BOTH	○ REMOVE HEALTH ○ REMOVE DENTAL ○ REMOVE BOTH

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

*LAST NAME		*FIRST NAME
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*RELATIONSHIP ○ CHILD ○ OTHER	*GENDER ○ MALE ○ FEMALE	*DATE OF BIRTH (MM/DD/YYYY)
☐ ADD DEPENDENT	QUALIFYING EVENT TYPE: ○ Marriage ○ Birth/Adoption ○ Loss of Coverage ○ Other	* DATE EVENT OCCURRED
☐ REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: ○ Divorce ○ Death ○ Entered Military Service ○ Request	* DATE EVENT OCCURRED
○ ADD HEALTH ○ ADD DENTAL ○ ADD BOTH		○ REMOVE HEALTH ○ REMOVE DENTAL ○ REMOVE BOTH

DEPENDENT

*LAST NAME		*FIRST NAME
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*RELATIONSHIP ○ CHILD ○ OTHER	*GENDER ○ MALE ○ FEMALE	*DATE OF BIRTH (MM/DD/YYYY)
☐ ADD DEPENDENT	QUALIFYING EVENT TYPE: ○ Marriage ○ Birth/Adoption ○ Loss of Coverage ○ Other	* DATE EVENT OCCURRED
☐ REMOVE DEPENDENT	REMOVE DEPENDENT DUE TO: ○ Divorce ○ Death ○ Entered Military Service ○ Request	* DATE EVENT OCCURRED
○ ADD HEALTH ○ ADD DENTAL ○ ADD BOTH		○ REMOVE HEALTH ○ REMOVE DENTAL ○ REMOVE BOTH

If any dependent child above is over the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification after age 26, please list any dependent child applying for student extension.

NAME OF CHILD		NAME OF SCHOOL	
NAME OF CHILD		NAME OF SCHOOL	

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health and/or dental plan or policy at the time this policy becomes effective? If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)	
NAME OF INSURANCE COMPANY	EMPLOYER'S NAME	
POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	GROUP NUMBER	TYPE COVERAGE ○ SINGLE ○ FAMILY

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete the information below.

If you have Individual coverage, please call Customer Service at **1-855-350-7441** to cancel your contract. If your Individual coverage is through the Federal Marketplace, please call the Marketplace at **1-800-318-2596** to cancel your contract.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	MEDICARE NUMBER

PART A ○	EFFECTIVE DATE (MM/DD/YYYY)	PART B ○	EFFECTIVE DATE (MM/DD/YYYY)
PART C ○	**EFFECTIVE DATE** (MM/DD/YYYY)	**PART D** ○	**EFFECTIVE DATE** (MM/DD/YYYY)

TO BE COMPLETED BY EMPLOYEE

☐ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Group Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group agent or Remitting Agent. I ask my Group to pay you directly and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health and/or dental policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

*SIGNATURE OF EMPLOYEE

DATE SIGNED (MM/DD/YYYY)		FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)	

TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME	*GROUP NUMBER

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION
*GROUP ADMINISTRATOR'S SIGNATURE	DATE SIGNED (MM/DD/YYYY)

IMPORTANT DISCLOSURE NOTICE

NOTICE OF GROUP HEALTH & DENTAL PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement as an eligible foster child, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, placement for adoption, or placement as an eligible foster child.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

NOTICE OF GROUP DENTAL PLAN BENEFIT WAITING PERIODS

This dental plan includes benefit waiting periods that you may have to serve before certain benefits begin to be covered under this dental plan. Please refer to the section in your benefit booklet called "Benefit Waiting Periods."

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE FOR GROUP HEALTH PLANS

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health andHuman Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-216-3144（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ
1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。