

Employee/Subscriber Information													
Social Security Number - -		BCBS Group No. - Suffix 31473 -		Date of Hire / /		Employee Department		Employee Group		Employee ID			
Effective Date / /		Last Name			First name			MI	Date of Birth / /		Home Phone ( ) -		
Home Address				City		State	Zip Code		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Work Phone ( ) -	
Plan: Community Blue PPO				Desired Action – Enroll or Cancel									
<input type="checkbox"/> Waive upon hire		<input type="checkbox"/> Terminate coverage		Reason for Enrollment				Reason for Cancellation					
<input type="checkbox"/> Single (employee only)		<input type="checkbox"/> Double (employee & 1 family member)		<input type="checkbox"/> Family (employee & 2 or more family members)		<input type="checkbox"/> New Hire/Rehire <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption/Foster Care <input type="checkbox"/> DEI Event <input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Return to Work (LOA) <input type="checkbox"/> Other Reason: <input type="checkbox"/> Cobra Enrollment <input type="checkbox"/> Transfer New Suffix:		<input type="checkbox"/> No Longer Employed <input type="checkbox"/> Deceased <input type="checkbox"/> Divorce <input type="checkbox"/> LOA <input type="checkbox"/> Other Reason :		<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Insurance <input type="checkbox"/> Loss of Dep Status	
List all dependents to be enrolled/cancelled			Last Name		First Name		MI	Gender	Date of Birth		Social Security		
<input type="checkbox"/> Spouse <input type="checkbox"/> DEI Adult		<input type="checkbox"/> Add <input type="checkbox"/> Remove						<input type="checkbox"/> M <input type="checkbox"/> F	/ /		- -		
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove						<input type="checkbox"/> M <input type="checkbox"/> F	/ /		- -		
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove						<input type="checkbox"/> M <input type="checkbox"/> F	/ /		- -		
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove						<input type="checkbox"/> M <input type="checkbox"/> F	/ /		- -		
<input type="checkbox"/> Child Age 19 - 26 <input type="checkbox"/> DEI Child <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Add <input type="checkbox"/> Remove						<input type="checkbox"/> M <input type="checkbox"/> F	/ /		- -		
If the permanent address of the spouse or child is different from the Employee, Please complete the information below													
Spouse/Child – Full Name			Street Address				City			State		Zip	
Child – Full Name			Street Address				City			State		Zip	
Do you, your spouse or children maintain other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below													
Full Name of Insured			Coverage Type		Insurance Company		Medicare Coverage						
							Part A Effective		Part B Effective		Claim Number		
			<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V				/ /		/ /				
			<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V				/ /		/ /				
I have read and understand the conditions, eligibility, & required documentation on Page 2.					HR USE ONLY 		HRA		Deduction Begin Date		Logged/Faxed to BCBSM		
Employee Signature			Date / /						/ /		/ /		

### **Please Read – Conditions for Enrollment/Cancellation**

- I hereby authorize my employer or successor to make deductions from my earnings of the required contributions or premiums for the group coverage provided in the policy or policies issued to my employer. Additionally, I understand the contribution for the medical plan is made on a pre-tax basis.
- Note: If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance coverage, you will not be able to enroll again until the next open enrollment period. The only exception by law is a qualified family status change or life event. The enrollment must take place within 31 days of the family change or life event.
- I understand that if my employment is terminated, by voluntary resignation, involuntary resignation, or by any other fashion or method, upon re-employment, coverage will not become effective until I again apply for it in accordance with the terms of the group policy.
- To the best of my knowledge and belief, the information I have provided is complete and correct.

### **Eligibility Definitions**

#### **Spouse**

1. The legal spouse of a Subscriber.

#### **Dependent Child**

1. Child of a Subscriber by birth; by legal adoption; by legal foster care; or by legal guardianship where the Subscriber is legally obligated by court order to provide health insurance.
2. Child of a Subscriber's spouse by birth; by legal adoption; by legal foster care; or by legal guardianship for whom the Subscriber is legally obligated by court order to provide health insurance.

**NOTE:** A child is considered legally adopted on the date of placement for adoption by an authorized placement agency. A child as defined above is eligible for coverage until the limiting age of 26 under all specified eligibility provisions, or if the child is incapable of self-sustaining employment by reason of a physical or mental disability that was incurred prior to the limiting age and the child is considered a dependent on the Subscriber's federal income tax return.

#### **Designated Eligible Individual (DEI)**

An employee who does not already enroll a spouse in health insurance may enroll one adult individual for coverage provided the adult, at the time of proposed enrollment, **resides** in the same residence as the employee and has done so for at least the previous 18 consecutive months. The employee may also enroll a dependent child of an adult DEI provided the child resides with the employee. The employee may not designate his or her IRS dependents, relatives, or tenants. To enroll a DEI, an employee must complete and submit with this form the DEI enrollment form.

#### **Family Status Change**

A family status change or life event includes an employee's marriage or divorce, death of a spouse or child, birth or adoption of a child, meeting the DEI requirements, a change in the employee or spouse's employment or an unpaid leave of absence by the employee or spouse.

### **Required Documentation**

#### **The following documentation is required for enrollment of a dependent**

1. Spouse – Copy of marriage certificate
2. Child – Copy of the birth certificate, proof of birth document from the hospital, or adoption or foster care placement paperwork
3. Stepchild – Copy of marriage certificate and the child's birth certificate
4. Disabled Child – Doctor's statement that certifies disability
5. Legal Obligation – Copy of the court order to provide health insurance to the specified dependent
6. Legal Guardianship – Copy of the court order entitling the Subscriber to full guardianship of the specified child
7. Designated Eligible Individual – DEI enrollment form and copies of the DEI's federal income tax returns to substantiate residency