BlueCross BlueShield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

Enrollment Form

PLEASE PRINT ALL INFORMATION

To Be Completed By Human Resources

Group Number	Effective Date	Employee Type: ☐ Active ☐ COBRA ☐ Retired ☐ Decline (If declining coverage, please complete page 2.)

Enrollment: ☐ New Hire ☐ Open ☐ Qualifying Event (check event and give event date; attach copies of legal documents for adoption, custody, guardianship, court order, MDHS, divorce) ☐ Adoption ☐ Birth ☐ Divorce ☐ Marriage ☐ Court Order ☐ Group Transfer ☐ New Hire ☐ Custody/Guardianship ☐ Loss of Coverage ☐ MDHS — Event Date:

Employee Occupation:

EMPLOYEE

Social Security Number	First Name	M.I.	Last Name:	Phone Number:

Mailing/Street Address	Apt./Ste	City	State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Other	Sex: ☐ Male ☐ Female	Birth Date:	Hire Date:	Medical Coverage Type: ☐ Employee ☐ Family ☐ Employee + Children ☐ Employee + Spouse	Dental Coverage Type: ☐ Employee ☐ Family ☐ Employee + Children ☐ Employee + Spouse

CREDITABLE COVERAGE

Did you have prior coverage? ☐ Yes ☐ No

If yes, enter **From** and **Through** dates. From: Through:

OTHER INSURANCE INFORMATION

Are you covered by any other insurance? ☐ Yes ☐ No

If yes, complete **"Other Coverage"** form.

DEPENDENTS

FULL NAME ➤ FIRST NAME / LAST NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE	SEX M/F	DATE OF BIRTH MO	DAY	YEAR	FULL-TIME STUDENT IF AGE 19 - 25	COBRA PARTICIPANT	OTHER HEALTH COVERAGE IF YES, COMPLETE **"OTHER COVERAGE"** FORM.	CREDITABLE COVERAGE IF YES, PROVIDE **FROM** AND **THROUGH** DATES. FROM	THROUGH
Husband/Wife											
Children											

Name of school for those age 19 and over _____

For myself and dependent's named above, I apply for health insurance coverage available through my Employer. I represent that all the information provided by me in this Enrollment Form is complete and accurate. I certify that I have read the above statements or that they have been read to me and that they are true and complete to the best of my knowledge. I understand that any misrepresentation of this information on my part may be used by my Employer to reduce or deny a claim for benefits as well as result in disciplinary action. I also agree to pay the appropriate fees for the coverage and authorize my Employer to deduct that amount from my wages and salary. Last, I acknowledge that the health insurance applied for is subject to all exclusions and limitations set forth in the Master Group Contract.

AUTHORIZATION (EMPLOYEE SIGNATURE)	DATE MO.	DAY	YR.

DECLINATION

Employee Name: _____ Social Security #: _____

Check which coverage declined. ☐ Medical ☐ Dental Employee ID#: _____

Occupation: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Sex: ☐ M ☐ F Hire Date: _____

NOTE: You must complete this form if you are waiving (declining) insurance coverage available to you through your Employer.

This is to certify that I have been given the opportunity to apply for group coverage available to me and my dependents pursuant to state law through my Employer. I proclaim that I was not pressured or forced by my Employer into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage, hereafter, that such subsequent applications shall be subject to the applicable terms and conditions of the Master Group Contract.

Date: _____ Employee Signature: _____