South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

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Companion Life

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MEMBERSHIP APPLICATION

SM Service Mark of the Blue Cross and Blue Shield Association.

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI): _____ **2.** Birthdate: _____/_____/_____ **3.** Male ☐ Female ☐

4. Address: (Street) _____ (City) _____ (State) _____ (ZIP) _____

5. Employee Social Security Number: __ __ __ - __ __ - __ __ __ __ **6.** Home Phone: (_____) _____-_____ E-mail: _____

7. Name of Employer: _____ **8.** Group No.: _____

9. Dept. No.:_____ **10.** Employer Identification No. (EIN):_____ **11.** Effective Date of Action Requested: _____/_____/_____

REASON FOR APPLICATION

12. ☐ New Member – **I am a full-time employee** ☐ Yes ☐ No **Full-time Date of Hire:** ___/___/___

☐ Coverage Change – Reason for Change:_____ Date of Occurrence:_____

☐ Late Enrollee ☐ Address Change ☐ Beneficiary Change ☐ Cancellation – Date Left Employment: _____ / _____ / _____

☐ Reinstatement – Reason: ☐ Return from Layoff ☐ Return from Leave ☐ Cancellation Error

☐ COBRA Qualifying Event:_____ Start Date: _____/_____/_____

☐ State Continuation – Start Date: ___/___/___ ☐ Sponsored Membership – Sponsored Member's Social Security Number: __ __ __ - __ __ - __ __ __ __

COVERAGE INFORMATION

Business Blue℠ Spectrum Plan Offered by Employer:	Complete	HDHP	HDHRA	True Blue®	Secure	Basic	True Blue Value
	☐	☐	☐	☐	☐	☐	☐

13. MEDICAL ELECTION

☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Family
☐ No Medical Coverage due to: (Check one)
- ☐ Other BlueCross BlueShield of SC Coverage (01)
- ☐ Covered by Military (03)
- ☐ Insurance with Another Company (02)
- ☐ Covered by Medicare (12)
- ☐ Covered by Spouse with this Employer (07)
- ☐ Other (05) Explain_____

14. DENTAL ELECTION

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ No Dental Coverage

15. LIFE COVERAGE (underwritten by Companion Life)

Life Class:_____ Life Amount: $_____

☐ Life Only (No Medical) ☐ Life and AD&D ☐ Dependent Life ☐ STD ☐ LTD

Earnings $_____ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Beneficiary Designation *(All Plans - applicable only if Life Coverage is available and selected)*

Primary: _____ Relationship: _____

Contingent:_____ Relationship:_____

ENROLLMENT INFORMATION (List all individuals to be covered.)

16.	Last Name	First Name	Birthdate	Male or Female	Social Security Number	Does individual have Medicare?	Status*
Employee						☐ Y ☐ N	
Spouse						☐ Y ☐ N	
Child						☐ Y ☐ N	
Child						☐ Y ☐ N	
Child						☐ Y ☐ N	
Child						☐ Y ☐ N	

*If an individual has Medicare, what is the reason? ESRD, disabled (under age 65), working aged (eligible due to age), inactive (retiree, COBRA, state continuation).

OTHER COVERAGE INFORMATION

17. Other than your coverage with this employer, do you or any of your family members have other health (including Medicare), dental or drug coverage? ☐ Yes ☐ No

Medicare Effective Date: _____ Health Insurance Claim Number (HICN):_____

If yes, what is the name of the insurance company and the Policyholder's ID Number: _____

18. Did you or any of your family members have health or dental coverage in effect prior to your coverage under this policy? ☐ Yes ☐ No

If yes, please attach a copy of the applicable Certificate of Coverage or other proof so that we can determine if you are eligible for credit toward your waiting period for pre-existing conditions.

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*

I hereby authorize the release of any medical or non-medical information about myself or eligible or enrolled dependents by any insurance company, medical professional, medical institution or other health care provider concerning the diagnosis, the treatment and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated, or claims denied if fraud or intentional misrepresentations of material facts have been made on this application subject to the Time Limit on Certain Defenses provisions. The statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for 12 months, then subject to pre-existing conditions for 6 months.

Signature: _____ **Date:** _____