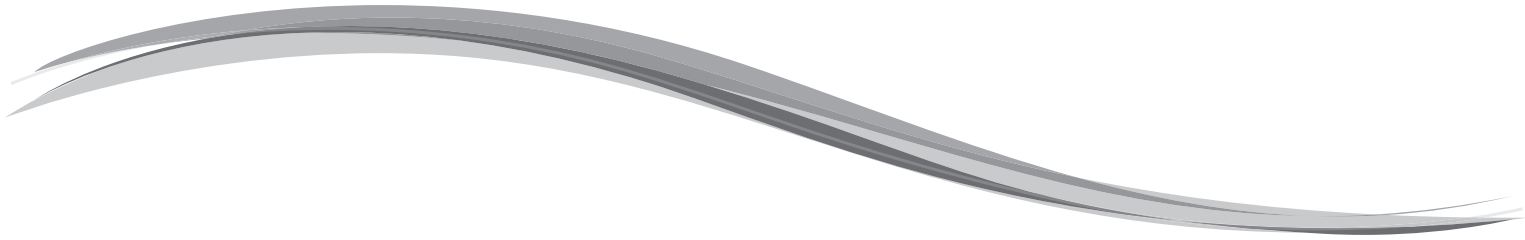
Small Business Enrollment Application/Change Form



Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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SMALL BUSINESS ENROLLMENT APPLICATION /CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION / CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all Sections where applicable.

Add Dependent: Complete all Sections where applicable.

- If you are adding or enrolling a dependent due to Adoption or Placement for Adoption, you must provide legal documents.
- If you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree.
- If you are applying for coverage for a disabled dependent child over the dependent age limit of your employer's plan, certification is required by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma. If certified disabled by Social Security, please attach a copy of the certification document. A disabled dependent over the dependent age limit of your employer's plan must be certified by medical underwriting.

Cancel Enrollee: Complete Sections 1, 2, 4, and 11. In Section 4 include name, social security number, and date of birth of individual(s) cancelling.

Cancel Dependent: Complete Sections 1, 2, 4, and 11. In Section 4 include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 9, and 11.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO only: Those applying for HMO coverage should select a PCP for each individual to be covered. List the name of the physician and the provider number from the provider directory or Provider Finder at **www.bcbsok.com**. Be sure to check the appropriate box for a new patient.

Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4, and 11. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address / Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2, and 11.

SECTION 5

Complete this section if you are applying for coverage for a disabled dependent child over the dependent child age limit of your employer's plan. A disabled dependent must be certified as disabled by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma. If certified disabled by Social Security, please attach a copy of the certification documentation.

SECTION 6

Complete this section unless you are applying for HMO.

The health coverage for which you are applying may have a preexisting condition waiting period. On your group's first contract date or contract anniversary date on or after September 23, 2010, a preexisting condition waiting period will not apply for individuals under the age of 19. Check with your employer if you have questions regarding preexisting condition waiting period applicability for individuals under the age of 19.

SECTION 7

Complete this section if you or any dependent has other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

SECTION 8

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 9

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 9, not just those declining because of other coverage.

IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or becoming a party in a Placement for Adoption, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption or Placement for Adoption.

SECTION 10

Complete this section for yourself or any of your dependents that will be covered if this coverage is approved.

SECTION 11

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer, who will then submit your form to: **Blue Cross and Blue Shield of Oklahoma • P. O. Box 3283 • Tulsa, OK 74112-3283 or via fax at 918-551-3179**

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the BCBSOK website at www.bcbsok.com, from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.

SMALL BUSINESS ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Oklahoma — BlueLincs, Blue Cross and Blue Shield of Oklahoma

Group No.	Section No.	Dept No.	Social Security No.
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 9, AND 11 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Change(s)**

Are you applying as a result of a Special Enrollment Event? ☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth, Adoption, Placement for Adoption (provide Legal documents)
☐ Court Order (see instructions)
☐ Loss of Other Coverage (provide Certificate of Creditable Coverage)
☐ Insure Oklahoma (O-EPIC Provide Approval Letter)
☐ Other (Explain) ____________

NOTE: Declination of Coverage (Complete Sections 2, 9, & 11)

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

List names of those cancelling in Section 4 below

Event: ☐ Divorce ☐ Death
☐ Terminated Employment
☐ Other

Indicate Event Date: ____ / ____ / ____

Cancel Coverage: ☐ Health ☐ Dental

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No.
					– –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	On average, how many hours do you work per week? (Required)

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ____________ ☐ COBRA Continuation

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Health Coverage (select one)
☐ BlueLincs HMO
☐ BlueChoice®
☐ BlueOptions®
☐ BlueOptimize℠
☐ BluePreferred®
☐ BlueTraditional®
☐ HSA BLUE
☐ Other/Plan No. ____________

Health Enrollees (select one)
☐ Employee Only
☐ Employee /Spouse
☐ Employee /Child(ren)
☐ Family
☐ I am not applying for health coverage

Health Deductible option $ ____________
(if more than one is available)

Dental Coverage
☐ Yes
☐ No

Plan No., if known: ____________

Dental Enrollees (select one)
☐ Employee Only
☐ Employee /Spouse
☐ Employee /Child(ren)
☐ Family
☐ I am not applying for dental coverage

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	Birth Date (MM/DD/YYYY)	Address (if different) - No. And Street Address	City	State	Zip
– –					

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, or adopted child ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild or adopted child, are you (or your spouse) financially responsible for this dependent ☐ Y ☐ N	

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, or adopted child ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild or adopted child, are you (or your spouse) financially responsible for this dependent ☐ Y ☐ N	

Dependent's Name: ____________ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, or adopted child ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild or adopted child, are you (or your spouse) financially responsible for this dependent ☐ Y ☐ N	

SECTION 5 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

A disabled dependent must be certified as disabled by the Social Security Administration and/or Blue Cross Blue Shield of Oklahoma.
If certified disabled by Social Security, please attach a copy of the certification documentation.

Last Name: Social Security No: | — — | Group #

SECTION 6 — PREVIOUS HEALTH COVERAGE INFORMATION

DO NOT COMPLETE IF APPLYING FOR HMO

In order to receive credit for preexisting condition waiting periods, you must provide information about the last 6 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a Certificate of Creditable Coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8. Please see instruction page for more information.

List names of every individual covered:

Previous Coverage Policyholder Name	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy No.	ID Number

Name of Previous Insurance Company, TPA, HMO:	Effective Date (MM/DD/YYYY)	Type of Coverage ☐ Health ☐ Dental	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Employer's Name:	Employment Date under Previous Coverage (MM/DD/YYYY)	Will Coverage be Continued? ☐ Health ☐ Dental If No, Expected Cancel Date (MM/DD/YYYY) _____

SECTION 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 9 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition waiting period.

Name ☐ Employee	Reason for Declining Health: ☐ Other Group Health Coverage; Carrier: _____ ☐ Indian Health Services ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining Dental: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

Last Name: Social Security No: — — Group #

SECTION 10 — STATEMENT OF HEALTH

Applicant	**Spouse**
Exact height: Feet _____ Inches _____ Exact weight: Pounds _____	Exact height: Feet _____ Inches _____ Exact weight: Pounds _____

MEDICAL QUESTIONNAIRE Answer these health questions (below) for each person applying for health coverage
Directions: Please check ☑ Yes ☑ No. If any box is checked "☑ Yes," circle the condition, e.g. STROKE and give details in "DETAILS OF MEDICAL HISTORY" section below.

1. Have you or any family member applying for coverage had a claim of $5000 or more in the last 12 months? ☐ Yes ☐ No
2. Have you or any family member applying for coverage been advised to have surgery or medical treatment in the last 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No
3. Have you or any family member applying for coverage been advised, diagnosed or treated in the last five years for:
   - A. Stroke, Circulatory Disease or Disorder, High Blood Pressure, Heart Disease or Disorder, Vascular Disease or Disorder ☐ Yes ☐ No
   - B. Cancer, Leukemia, Chronic Skin Condition, Tumors, Lupus, Any other Systemic Disease ☐ Yes ☐ No
   - C. Multiple Sclerosis, Osteoarthritis, Joint Disorders, Muscle Disorders, Paralysis, Other Severe Arthritis, Back Disorders, Bone Disorders ☐ Yes ☐ No
   - D. Asthma, Respiratory and Lung Disorders, Emphysema ☐ Yes ☐ No
   - E. Diabetes, Growth Disorders, Pancreas, Endocrine Disorder ☐ Yes ☐ No
   - F. AIDS, Immune System Disorders, Tested Positive for HIV, Blood Disorders ☐ Yes ☐ No
   - G. Hepatitis, Digestive System Disease or Disorder, Kidney Disorder, Reproductive Organs Disorder, Urinary Tract Disorder, Liver Disorder, Colon Disorder, Prostate Disorder, Infertility ☐ Yes ☐ No
   - H. Nervous System/Brain/Seizure Disorders, Alcohol/Drug/Substance Abuse or Dependency, Mental/Emotional Disorders ☐ Yes ☐ No
   - I. Organ Transplant, Bone Marrow Transplant ☐ Yes ☐ No
   - J. Pregnancy ☐ Yes ☐ No
   - K. Other ☐ Yes ☐ No
4. Are you or any family member applying for coverage currently pregnant? ☐ Yes ☐ No

Details of Medical History
If you have answered "YES" to any of the questions above, please provide details below for each person with the condition. If more than one person has the condition, add a separate entry for each person. See example in the first line. Attach additional sheet if necessary.

Name of Person with Condition (Optional)	Age	Gender	Relation to Insured	Condition/Prognosis Details	Treatment/Medication Details	Date(s) Treated	Current Status
John Doe	12	M	Child	Appendicitis	Surgery to remove appendix	10/21/10 to 10/23/10	Full Recovery

SECTION 11 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Oklahoma (BCBSOK). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- For individuals age 19 and over, I understand that the Health coverage for which I am applying may have a preexisting condition exclusion waiting period. (Does not apply to HMO.)
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Applicant's Signature _____ Date _____