PREMERA | BLUE CROSS

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www.premera.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

1. GROUP INFORMATION (to be completed by the group)

Group ID	Group name	☐ New ☐ Change	Reason	Date of event / /
Employee class (if applicable)	Employee job title	Employee date of hire / /	Date employee entered eligible class ☐ Same as hire date ☐ Other date / /	Effective date / /

If COBRA, indicate number of months eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months

If State Continuation (COC), eligible period of coverage cannot exceed 3 months.

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last) (First) (MI)	☐ Married ☐ Unmarried	Home phone ( )	Work phone ( )
Home address City State ZIP	Mailing address (if different than home address) City State ZIP		

3. ENROLLMENT INFORMATION

Plan choice

NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit.
Please indicate each member's name as you would like it to appear on the ID card. ID card names are limited to 26 characters and spaces.

Add	Drop	Relationship to Employee	Last Name	First Name	MI	Social Security No.	Date of Birth	Gender		Benefit Selection	
								Male	Female	Medical	Dental
☐	☐	Self					/ /	☐	☐	☐	☐
☐	☐	Spouse					/ /	☐	☐	☐	☐
☐	☐						/ /	☐	☐	☐	☐
☐	☐						/ /	☐	☐	☐	☐
☐	☐						/ /	☐	☐	☐	☐
☐	☐						/ /	☐	☐	☐	☐

Does a dependent have a different mailing address? ☐ No ☐ Yes, complete the following: Dependent's Name (Last, First, MI) _____

Dependent's mailing address _____ City _____ State _____ ZIP _____

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes, complete and attach the *Request for Certification of Disabled Dependent* form.

Has any applicant had health insurance coverage at any time during the past 3 months before your enrollment date on this plan? (If prior coverage information is not provided, the full waiting period will apply.)

☐ No ☐ Yes If yes, who was covered? ☐ Employee ☐ Spouse ☐ Dependent Children Date coverage began ___/___/___ Date coverage ended ___/___/___

Will any applicant have other current health coverage including Medicare or Premera, which will remain in effect when your Premera coverage begins?

☐ No ☐ Yes, please complete and attach the *Other Coverage Questionnaire* form.

4. EMPLOYEE SIGNATURE

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted.

Employee signature_____ Date signed _____ / _____ / _____

Please note: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

An Independent Licensee of the Blue Cross Blue Shield Association

PREMERA PRIVACY POLICY AND NOTIFICATION PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other health-care plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at www.premera.com. To have forms mailed to you, please call the number below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan at a future date, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

LATE ENROLLEES

A “Late Enrollee” is an individual or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify as a Special Enrollee. If you or your dependents are Late Enrollees, you or your dependents may enroll during the next occurring Annual Group Enrollment Period.

PRE-EXISTING CONDITION WAITING PERIOD

Your plan includes a waiting period for pre-existing conditions. A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in a period of time that ends on your “enrollment date.” This “look-back” period is 6 months if your employer has 50 or fewer employees or 3 months if your employer has more than 50 employees. The “enrollment date” is the employee's date of hire for an employee and eligible dependents who enroll when the employee is first eligible. If an employee is transferring from an ineligible class of employees, the enrollment date is the date the employee entered the eligible class. For everyone else, the enrollment date is the date coverage starts. Your waiting period for pre-existing conditions will be 9 months from your enrollment date if your employer has 50 or fewer employees or 3 months if your employer has more than 50 employees.

Please check with your employer if you have a question regarding the total number of employees in your company.

Benefits won't be provided for pre-existing conditions until after your coverage becomes effective and your waiting period for pre-existing conditions has been met. The length of your waiting period for pre-existing conditions may be reduced by periods of "creditable" coverage (see below) you've accrued under other health care plans prior to your enrollment date for this plan. You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 3 months. Any coverage you had before a break in coverage which exceeds 3 months isn't credited toward your waiting period for pre-existing conditions.

Please complete the prior coverage information in section 3 of the enrollment form **or** attach a copy of the Certificate of Creditable Coverage you received from your prior insurance carrier to this application. If you do not have a Certificate of Creditable Coverage, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. If you need help to obtain creditable coverage information from your prior plan or prior insurance carrier, please call us at the number listed below and we will help you. If prior coverage information is not provided, the full waiting period will apply.

CREDITABLE COVERAGE

“Creditable Coverage” means prior or ongoing health care coverage including any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children’s Health Insurance Programs (SCHIP), a public health plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

If you have any questions about the information included in this notice, please call us at 1-800-722-1471.