Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

GROUP EMPLOYEE APPLICATION

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Please print clearly and complete the entire form in ink.

Please check the appropriate box and fill in blanks below in ink.

❑ Arkansas Blue Cross and Blue Shield ❑ Health Advantage

Group No. __________________ **Employer** ____________________________ **ID No.** __________________

Group Administrator Use Only

Multi-option: which

____

Is the employee waiving coverage in the plan? ❑ Yes ❑ No If yes, complete Sections 2, 6 and 9 only.

FOR OFFICE USE ONLY

Date of Full-Time Employment	❑ COBRA Effective Date	❑ COBRA Termination	Reason for COBRA:
Mo / Day / Year	Mo / Day / Year	Mo / Day / Year	______________________

Are you a current, active employee? ❑ Yes ❑ No If no, retirement date: ______________________

SECTION 1 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

	Date		Date
❑ 1–Annual Open Enrollment Period		❑ 6–Marriage	__________
❑ 2–New Hire		❑ 7–New Adoption	__________
❑ [3–New Enrollee-Life Only] (Omit Section 7)		❑ 8–New Guardianship/Legal Custody/Court Order to Add Child	__________
❑ 4–Loss of Minimum Essential Coverage	__________	❑ 9–Other Reason: Ex. Rehire, ACA (give specific reason)	__________
❑ 5–Newborn	__________	______________________________	

NOTE: If application is **not** received during Open Enrollment Period, we must receive appropriate documentation with this Application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.).

SECTION 2 | WHO IS APPLYING

Complete this section on all members to be covered or waived.
NOTE: Dependents of **small groups** are not required to complete this section if waiving coverage.

Coverage Desired: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

Please indicate under the relationship column below whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.	Waiving (✓)	$Amt Deductible Credit Submitted	Primary Care Physician	PCP Number (NPI#)
			Self							

*Deductible Credit is available for new group enrollments with Arkansas Blue Cross (not Health Advantage) but only if the individual requests it on this initial application.

☐ **Important Opt-In Consent for Electronic Document Access and Delivery**: By providing your email address or by checking this box, you agree that after enrollment we may communicate with you and provide your policy information to you electronically for your convenience, such as your health insurance plan documents, benefits, ID cards, explanation of benefits, claim status, and legal notices regarding your financial, privacy and healthcare rights under federal law. Opting into electronic delivery also allows us to communicate with you electronically, either directly or through one of our contracted business associates, regarding your plan, identification of healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment options, care coordination, and case management assistance for you in connection with your plan through [Arkansas Blue Cross Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas or Skai Blue Cross and Blue Shield] ("Plan"). Please note that you are responsible for updating your contact information. This electronic delivery will continue through any policy renewals or other changes. Once you are an enrolled member of a plan, if you want to change your communication preferences, including to opt-out of electronic delivery, you may:

- Update your communication preferences and/or contact information at https://blueprintportal.com

OR

- Call the Customer Service number located on your member ID card

If you register for Blueprint portal access after enrollment, this allows you to access your documents and information electronically through your own password-protected account. With the Blueprint portal, your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge, or Safari. You may also set your preferences at https://blueprintportal.com.

Consent to electronic delivery is not a condition of purchase, enrollment, or coverage. At no cost to you, you also may request a paper copy of a document, regardless of whether it is or has been delivered electronically.

By providing your mobile phone number, you agree that automated, informational text messages may be sent to you by or on behalf of your Plan to update you about new plan products and programs.
Standard mobile phone and/or text message charges may apply from your wireless provider. Frequency will vary.

SECTION 3 | MARITAL STATUS

❑ Single (including widowed or divorced) ❑ Married (including separated)

SECTION 4 | CONTACT INFORMATION

Street or P.O. Box ____________________ City ____________________ State ______ ZIP __________

Primary Phone Number ( ) ______________ Work Phone Number ( ) ______________ Email ____________________

SECTION 5 | EMPLOYMENT STATUS

Job Title ______________________ Tax ID* (EIN) ____________
*For 1095 Reporting

❑ Hourly Hours Worked Weekly __________ ❑ Salaried ❑ Other ____________

FOR OFFICE USE ONLY

C/T	PKG	[LIFE]
EFF DATE	UND	DATE
OTH		

SECTION 6 | WAIVER OF ENROLLMENT

To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.

Medical Coverage Declined for:
- ❑ Myself
- ❑ Spouse
- ❑ Dependents

❑ Covered by spouse's group coverage – Carrier Name and ID:

❑ Enrolled in other insurance carrier plans – Carrier Name and ID:

❑ Medicare ❑ Medicaid ❑ Covered by TRICARE or CHAMPVA

Other (Explain):

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I will be deferred until open enrollment.

SECTION 7 | CURRENT/PREVIOUS INSURANCE INFORMATION
(This section must be completed to process your enrollment application.)

For previous or continuing coverage please complete the following:
(If covered by more than one insurance plan, use additional paper)

Insurance Company	Address	Phone
Policyholder Name	Date of Birth	Member ID#

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Eff. Date of Coverage	End Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? ❑ Yes ❑ No
If no, please name responsible party: ______________________

On the day coverage begins will any family members be covered by **Medicare**? ❑ Yes ❑ No
If yes, answer all questions below. (Use additional paper if necessary)

Reason for Medicare coverage: ❑ Over 65 ❑ Disabled ❑ Kidney Disease

Medicare Beneficiary Name: Relationship of Beneficiary to Policyholder:

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply): ❑ Medicare Part A – Effective Date: ________ ❑ Medicare Part B – Effective Date: ________

[SECTION 8 | LIFE INSURANCE (Issued by USAble Life if purchased by your employer)]

[*USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield and Health Advantage. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield or Health Advantage products. USAble Life is solely responsible for life insurance.*

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.]

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 9 | SIGNATURES (Please read before signing)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas Blue Cross and Blue Shield, Health Advantage and [USAble Life] group policies with my employer and may from time to time be amended. I understand that coverage will not become effective before the approved effective date.

In signing this application, I represent that the statements and answers given in this application are true, complete and correctly recorded. I understand that Arkansas Blue Cross and Blue Shield, Health Advantage or [USAble Life]may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas Blue Cross and Blue Shield, Health Advantage or [USAble Life] may take legal action at any time. Arkansas Blue Cross and Blue Shield, its affiliates and partners may contact you, either directly or through a business associate, using your email address or telephone number regarding your health insurance plan or other promotional opportunities. You can manage your preferences or unsubscribe in Blueprint Portal at blueprintportal.com.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

______________________	______________________	__________
Print Name of Applicant (Employee)	Signature of Applicant (Employee)	Date
Print Name of Employer/Group Representative*	Signature of Employer/Group Representative*	Date

**Required for new hires and additions only.*