

GROUP PRODUCT ENROLLMENT AND CHANGE FORM

Please complete this application in blue or black INK. DO NOT USE A PENCIL OR A HIGHLIGHTER.



An Independent Licensee of the Blue Cross Blue Shield Association

HIPAA COMPLIANT

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental application from your Group Administrator.

Social Security Number	Group Number	Group Name	Effective Date	Dept. Code

Level of Benefits Applied for:
 Single
 Adult & Child
 Two Adults
 Adult & Child(REN)
 Family

Coverage Applied for:
 New Blue
 SuperBlue Plus
 SuperBlue Select
 Other

REASON FOR COMPLETION:
 New Enrollee
 Changes (see below)
 Cancel (see below)
 Re-enrollment

COBRA Start Date _____ COBRA End Date _____ (see below)

DEPENDENT CHANGES:	OTHER CHANGES:	CANCEL/COBRA REASON:
Add Dependents due to: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Date of Above Event _____	<input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage <input type="checkbox"/> Other _____ Date of Above Event _____	<input type="checkbox"/> Deceased <input type="checkbox"/> Left Employment <input type="checkbox"/> Involuntary Lay-Off <input type="checkbox"/> Other Coverage <input type="checkbox"/> Other _____ Date of Above Event _____
Drop Dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____		

Applicant's Last Name (Please Use the Boxes) _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____ County _____

Birthdate	Phone Number	Gender	Marital Status	Date Married
Mo Da Yr	()	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Mo Da Yr

Employment Status	Date of Full Time Hire	Hours Worked	Job Title
<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra	Mo Da Yr	Per Week	

COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	Birthdate Mo/Da/Yr	Gender M/F	Last Name	First Name	Social Security #	Dependent Status if Over Age 19
SPOUSE						
<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other.

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S).

I HEREBY DECLINE COVERAGE	REASON FOR DECLINING COVERAGE:
<input type="checkbox"/> For MYSELF <input type="checkbox"/> For MYSELF and ALL FAMILY MEMBERS <input type="checkbox"/> For FAMILY MEMBERS ONLY <input type="checkbox"/> For the FOLLOWING PERSON(S) _____	<input type="checkbox"/> HAVE NOT MET EMPLOYER'S ELIGIBILITY <input type="checkbox"/> INSURED UNDER SPOUSE'S CONTRACT with the following Insurance Carrier _____ <input type="checkbox"/> OTHER _____

I Hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment occurs before coverage will be offered. Any pre-existing conditions specified in the contract will apply.

Signature _____ Date _____

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, 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.

STOP HERE IF DECLINING COVERAGE FOR YOURSELF

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Have you or any of your dependents had previous health coverage? **YES** **NO. If "YES", complete the following boxes, including the effective and cancel dates.**

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date	Cancel Date	Coverage Type(s)
					<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision

REASON FOR CANCELING

MOST RECENT COVERAGE:

The above section can be used by MSBCBS in lieu of Certificate of Coverage and will be used, in part, as the basis in determining the pre-existing condition waiting period, if applicable. MSBCBS may require other documentation such as Certificate of Coverage, EOB's, etc. in determining pre-existing condition waiting periods. YOU have a right to demonstrate creditable coverage and to request a Certificate of Coverage from a prior carrier.

Medicare Information - Check the appropriate boxes and fill in all information for you and any dependents who are covered by Medicare.

<input type="checkbox"/> You	Medicare # _____	Eff. Date - Part A: / /	Part B: / /	<input type="checkbox"/>	Check this box for each individual who is receiving treatment for end-stage renal disease.
<input type="checkbox"/> Spouse	Medicare # _____	Eff. Date - Part A: / /	Part B: / /	<input type="checkbox"/>	
<input type="checkbox"/> Dependent	Medicare # _____	Eff. Date - Part A: / /	Part B: / /	<input type="checkbox"/>	

MEDICAL HISTORY INFORMATION

YOUR HEIGHT (ft./in.) _____ YOUR WEIGHT (lbs.) _____ SPOUSE'S HEIGHT(ft.in.) _____ SPOUSE'S WEIGHT (lbs.) _____

Have you or any of your dependents EVER had any of the conditions listed below? If so, please indicate by marking "X" in each appropriate box. List in the Explanation Section the patient's name, diagnosis, treatment(s) and treatment date(s), surgeries and surgery date(s), and the prognosis for each condition marked.

1. CANCERS

Site of cancer _____ List all other requested information in the Explanation Section.

2. HEART/LUNG

- Anemia
- Aneurysm
- Arteriosclerosis
- Congenital Heart Disease
- Congestive Heart Failure
- Heart Attack
- Hemophilia
- Hypertension
- Ischemic Heart Disease
- Rheumatic Heart Disease
- Stroke
- Valvular Disease
- Apnea
- Asthma
- Cystic Fibrosis
- Emphysema
- Tuberculosis

4. IMMUNE

- AIDS
- ARC - AIDS Related Complex
- Any Immune Suppressed Illness
- HIV-list status in Explanation Section
- Kaposi's Sarcoma
- Systemic Lupus

5. RENAL

- Blood in Urine
- Dialysis
- Polycystic Kidney Disease
- Renal Failure

Acute _____ Chronic _____

6. DIGESTIVE/INTESTINAL

- Cirrhosis of Liver
- Colostomy
- Crohn's Disease
- Diabetes: Juvenile ____ Adult ____
- Diet Controlled ____ Oral Medications ____
- Insulin ____ Units/Day ____
- Hepatitis Type: A ____ B ____ C ____
- Pancreatitis
- Ulcertive Colitis

7. NEUROLOGICAL/PSYCHOLOGICAL

- Alzheimer's
- Amyolateral Sclerosis ---- Lou Gehrig's Disease
- Attempted Suicide
- Cerebral Palsy
- Depression
- Drug/Alcohol Abuse
- Multiple Sclerosis
- Paralysis
- Parkinson's
- Spina Bifida: Cystica ____ Occulta ____

8. MUSCULAR/SKELETAL

- Amputation
- Arthritis: Rheumatoid ____ Osteo ____
- Degenerative Disc or Joint Disease
- Herniated Disc
- Joint Replacement
- Marfans Syndrome
- Muscular Dystrophy

9. REPRODUCTIVE

- Infertility: In Vitro ____ GIFT ____
- Pregnant, Due Date: ____/____/____
- Sexually Transmitted Disease(s)
- Other Reproductive

3. HEART/LUNG TREATMENTS

- Angioplasty
- Bypass
- Cardiac Catherization
- Pace Maker Implantation
- Heart Valve Replacement

ANY QUESTIONS BELOW ANSWERED WITH A "YES" MUST BE EXPLAINED IN THE EXPLANATION SECTION

- | | | |
|--------------------------|--------------------------|---|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you or any of your dependents ever had or been advised to have an organ or bone marrow transplant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you or any of your dependents have any other medical conditions not listed above that have been diagnosed or treated by a health care provider in the past FIVE years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you or any of your dependents been hospitalized or had surgery within the past FIVE years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you or any of your dependents been advised to have surgery which has not been performed yet? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you or any of your dependents currently taking prescription medications? If yes, please list patient's name, name of medication, dosage, and the reason taking the medication in the Explanation Section. |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you or any of your dependents been treated by a health care provider six months prior to your hire date? If yes, please explain. |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you or any of your dependents ever been covered by Worker's Compensation, Disability, or Subrogation for any of the conditions listed in the Medical History Section above? |

EXPLANATION SECTION

Provide explanation for each box marked in questions 1 - 9 and for each box marked "YES" in questions 10 - 16 from the previous page. If additional space is needed, use the Other Information section below. Attach additional sheets if needed.

Question #	Patient Name	Hospitalization Date(s)	Treatment Dates From/To	Diagnosis, Treatment, Prognosis, and Medications/Dosages

OTHER INFORMATION (Continue on Separate Paper if Necessary)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

THIS SECTION MUST BE COMPLETED ONLY WHEN ENROLLING IN A SUPER BLUE SELECT PRODUCT

Family Member Name First, Middle, Last (include Yourself)	Primary Care Physician (PCP) (First and Last Name)	PCP ID# (as listed in Directory)	Are you an Existing Patient of this PCP?	
			Y	N
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Do any of the dependents listed above live in a different city? Y or N. If yes, list below the dependent(s) and the city and state in which they live.

1. Dependent _____ City & State _____ 2. Dependent _____ City & State _____

IMPORTANT: APPLICATION FOR COVERAGE

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or rescission of coverage and may subject me to legal action by Mountain State Blue Cross & Blue Shield. I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Mountain State Blue Cross & Blue Shield unless and until this Application for coverage is approved and I have been provided with an Effective Date and Group Number, and only as long as the Group continues to qualify under the terms of the Group contract with MSBCBS, including timely payment of premiums.

If applicable, I understand that unless I or my dependents qualify as "Eligible Individuals", as that term is defined by the Health Insurance Portability and Accountability Act of 1996, that this MSBCBS coverage will not pay for any loss incurred during the first twelve (12) months after the effective date for any condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period prior to the enrollment date of coverage. Please see your health care certificate for a more detailed explanation. I also understand that if I am a "late entrant" I am subject to an eighteen (18) month pre-existing condition waiting period. HOWEVER, waiting periods will be reduced by eligible certified Creditable Coverage, as defined by the Health Insurance Portability and Accountability Act of 1996, incurred within sixty-two (62) days prior to the effective date of this Mountain State Blue Cross & Blue Shield coverage.

Applicant's Signature _____

Date _____

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
Memb RQ Date	Membership Received Date (2)	On MCDP
Memb Rec RQ Date		Off MCDP
Completed or Closed	Verified	ID Mailed

Date Approved _____

Approved By _____

Date Denied _____

Coverage Effective Date _____

Waiting Period Covered _____

Date Rec'd by Membership _____

Date on System _____

Send to:

MOUNTAIN STATE BLUE CROSS BLUE SHIELD

P.O. Box 1948

Parkersburg, WV 26102