Respiratory Education Program

ENROLLMENT FORM

Please print clearly, fill out completely, sign and return to your regional office.

NAME _____ (Last) _____ (First)

PHONE NO. (home) ___ - ___ - ____ (Area Code)

ADDRESS _____ (Street or P.O. Box)

PHONE NO. (work) ___ - ___ - ____ (Area Code)

CITY _____ STATE _____ ZIP _____ - _____

SOCIAL SECURITY NO. ___ - ___ - ____ (This will be your ID no. for this program.)

E-mail Availability: Yes / No (Circle one.)

E-MAIL ADDRESS _____

PHYSICIAN NAME _____ (Last) _____ (First)

ADDRESS _____ (Street or P.O. Box)

CITY _____ STATE _____ ZIP _____ - _____

In order to assist us in identifying health education needs, please answer the following questions by circling the correct answer:

1) Have you ever worked with an Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage Administrators of Arkansas regional case manager? Yes / No If yes, case manager's name: _____

2) Did you get a flu shot last year during the usual flu season (Sept.-Dec.)? Yes / No

3) Have you **ever** had a pneumonia shot? (This immunization was first made available in 1977 and is usually given once in a lifetime.) Yes / No

4) Are you a smoker? Yes / No

5) How many days of work did you miss last year due to a respiratory illness?

A. 0 days B. 1-3 days C. 4-5 days D. More than 5 days E. Unemployed/Retired

We are very interested in providing you with information regarding respiratory health. Please list below any topics that you would like to see included in the Respiratory Education Program materials. (Use the back of this form, if necessary.)

_____

_____

I understand and agree that the information provided on this form is to be used by Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas to provide health educational and informational resources regarding respiratory health.

By my signature, I hereby indicate my decision to enroll in the Respiratory Education Program. I understand that there is no cost to me or my family for this program. I further authorize Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage to communicate with my physician(s) regarding any related treatment or records of treatment, and to release my identity and related records for the purpose of my participation in the Health Survey and other aspects of the Repiratory Education Program as described in the Respiratory Education Program brochure.

Signature (Required): _____ **Date:** _____

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

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

BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. 10-99REP-OL R1/03

Welcome to the Program!