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

GROUP EMPLOYEE APPLICATION with MEDICAL QUESTIONNAIRE

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.

❑ 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 10 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: _____

FOR OFFICE USE ONLY

C/T	PKG
DATE	EFF DATE
UND	OTH

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 (50 or fewer employees) 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#)	Was This Your Regular Physician?
			Self								Yes/No
											Yes/No
											Yes/No
											Yes/No
											Yes/No
											Yes/No
											Yes/No

*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.

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 _____

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 | MEDICAL INFORMATION

All of the following questions must be answered in the employee's own handwriting (in ink) for each person applying for coverage. Use a separate sheet, if necessary; sign, date and attach to the questionnaire.

In the past 5 years, has any person to be insured ever been diagnosed or been advised to have treatment or care for any of the following conditions? ***Please check the appropriate response below and explain in boxes provided.***

	Y	N	
1.	❑	❑	Premature delivery / Newborn complications
2.	❑	❑	Organ / Bone marrow transplant
3.	❑	❑	Cancer / Leukemia
4.	❑	❑	Any immune system disorder
5.	❑	❑	Hepatitis / Liver disease
6.	❑	❑	Cystic Fibrosis / COPD
7.	❑	❑	Multiple Sclerosis / ALS
8.	❑	❑	Acute / Chronic kidney disease
9.	❑	❑	Spinal cord injury
10.	❑	❑	Any planned surgeries in the next 12 months or any surgeries in the past 12 months?
11.	❑	❑	Stroke or seizures No. of episodes: _____
12.	❑	❑	Tobacco use
13.	❑	❑	Have you had medical claims in excess of $10,000 in the last 24 months?
14.	❑	❑	Any admissions to a hospital?
15.	❑	❑	Any condition not listed above?

Item #	Name	Date Occurred	Last Treated	Diagnosis	**Prognosis** (planned or continuing treatment or medication)

SECTION 10 | 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.

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.*

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