Group employee application

Please print clearly and complete the entire form in ink.

Employer	Tax ID	Employee Name

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

☐ Arkansas Blue Cross and Blue Shield ☐ Health Advantage ☐ Dental ☐ Vision

Medical group #	Dental group #	Vision group #
ID #	**ID #**	**ID #**

Group administrator use only
Multi-option: which

Are you a current, active employee?	If yes, date of full-time employment	If no, retirement date
☐ Yes ☐ No		
☐ **COBRA effective date**	☐ **COBRA Termination**	**Reason for COBRA**

Is the employee waiving all coverage in the plan, including life?
☐ Yes ☐ No

If yes, complete Sections 2, 6 and 9 only.

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 (Embedded USAble Life plans)		☐ **8** – New guardianship/Legal custody/Court order to add child	
☐ **4** – Loss of minimum essential coverage		☐ **9** – Other reason - Ex. Rehire, APTC (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. Please do not attempt to enroll in coverage that is not currently offered by your employer.

Note: Dependents of small groups are not required to complete this section if waiving coverage.

Coverage desired

Medical:	☐ Employee	☐ Employee + Spouse	☐ Employee + Children	☐ Family
Dental:	☐ Employee	☐ Employee + Spouse	☐ Employee + Children	☐ Family
Vision:	☐ Employee	☐ Employee + Spouse	☐ Employee + Children	☐ Family

Section 2 - Who is applying (continued)

Please indicate whether dependent children are natural (N), step (S) or adopted (A).						*Coverage desired Enroll (E) or Waiver (W)			$ Amt Deductible Credit Submitted	Primary Care Physician and PCP Number (NPI#)
Social Security Number	First name	M.I.	Last name	Sex	Date of birth	Medical	Dental	Vision		
Employee - -										
Spouse - -										
Child ☐N ☐S ☐A - -										
Child ☐N ☐S ☐A - -										
Child ☐N ☐S ☐A - -										
Child ☐N ☐S ☐A - -										
Child ☐N ☐S ☐A - -										

* Deductible Credit is available for new group enrollments with Arkansas Blue Cross medical (not Health Advantage, Dental or Vision plans) and only if the individual requests it on this initial application. It is only allowed at the group's initial enrollment when an employer is moving from a previous group medical plan.

Section 3 - Marital status

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

Section 4 - Contact information

Street or PO box	City	State	ZIP

Primary phone number	Work phone number	Email

Section 5 - Employment status

Job title

☐ Hourly ☐ Salary ☐ Other

Hours worked weekly
(required regardless of salary type)

FOR OFFICE USE ONLY	C/T	OTH	Life
	Eff Date	UND	Date
	PKG/Division		

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

Reason

☐ 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.
Do not complete if you checked 3-New Enrollee Life Only in Section 1.

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

Previous insurance carrier information

Insurance company	Address	City	State	Phone	Member ID
Medical					
Dental					
Vision					

List the following information for all family members covered by this policy

First name	Last name	Relationship	Reside in same household?	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.

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.