

BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE

- BLUE PREFERRED (PPO)
BLUE PREFERRED SAVER (PPO)
BLUE CLASSIC (INDEMNITY)
BLUECHOICE (HMO)
BLUE SELECT (HMO)

OPTION

MEDICAL COVERAGE

- EMPLOYEE ONLY
EMPLOYEE & SPOUSE
EMPLOYEE & CHILDREN
FAMILY

DENTAL CHOICE COVERAGE

- EMPLOYEE ONLY
EMPLOYEE & SPOUSE
EMPLOYEE & CHILDREN
FAMILY

WAIVER OF COVERAGE

- SELF
SPOUSE
DEPENDENT(S)

FOR THOSE EMPLOYEES AND DEPENDENTS DECLINING COVERAGE, SELECT THE APPROPRIATE REASON CODE FROM THE BACK OF THE FORM AND ENTER BELOW.

- NEW GROUP OPEN ENROLLMENT

SECTION I - INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME LOCATION GROUP NUMBER JOB CLASSIFICATION

SECTION II - INFORMATION REGARDING THE EMPLOYEE

MARK ONE: ADD CHANGE WAIVER SOCIAL SECURITY NUMBER LAST NAME FIRST NAME M.I. APARTMENT NO. MAILING ADDRESS (NUMBER & STREET) CITY STATE ZIP + FOUR HOME TELEPHONE (AREA CODE AND NO.) DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE MARRIED SINGLE DATE OF MARRIAGE (MM/DD/YYYY) HOURS WORKED PER WEEK DATE OF FULL TIME EMPLOYMENT WORK TELEPHONE (AREA CODE AND NO.) EMAIL ADDRESS See reverse side (I) regarding e-mail authorization.

OTHER CARRIER INFORMATION: Will you or your dependents be covered by other health insurance in addition to BCBSAZ? YES NO Do you currently have or have had other coverage within the last 18 months? YES NO If yes, please complete the other carrier information below. CARRIER NAME CARRIER PHONE NO. (AREA CODE AND NO.) CONTRACT HOLDER LAST NAME ID/SOCIAL SECURITY NUMBER GROUP/POLICY NO. EFFECTIVE DATE (MM/DD/YYYY) CANCEL DATE (MM/DD/YYYY) MEDICARE CARD NO. PART A EFFECTIVE DATE PART B EFFECTIVE DATE

Complete the following for all dependents. If you have more than 3 dependents, complete a separate form. If any of your dependents currently have or have had other health coverage within the last 18 months, please complete the other carrier information for each covered dependent. New employees: Complete the following information for each eligible dependent including those declining or waiving coverage. Enrolled employees: to add or remove dependent(s) or change coverage options, only include the persons affected by the change.

1 MARK ONE: ADD DELETE CHANGE WAIVER LAST NAME FIRST NAME M.I. SOCIAL SECURITY NUMBER DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE RELATIONSHIP NAME OF OTHER INSURANCE CARRIER CARRIER PHONE NO. (AREA CODE & NO.) CONTRACT HOLDER LAST NAME IDENTIFICATION NUMBER GROUP/POLICY NO. EFFECTIVE DATE (MM/DD/YYYY) CANCEL DATE (MM/DD/YYYY) MEDICARE CARD NO. PART A EFFECTIVE DATE PART B EFFECTIVE DATE

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3 MARK ONE: ADD DELETE CHANGE WAIVER LAST NAME FIRST NAME M.I. SOCIAL SECURITY NUMBER DATE OF BIRTH (MM/DD/YYYY) MALE FEMALE RELATIONSHIP NAME OF OTHER INSURANCE CARRIER CARRIER PHONE NO. (AREA CODE & NO.) CONTRACT HOLDER LAST NAME IDENTIFICATION NUMBER GROUP/POLICY NO. EFFECTIVE DATE (MM/DD/YYYY) CANCEL DATE (MM/DD/YYYY) MEDICARE CARD NO. PART A EFFECTIVE DATE PART B EFFECTIVE DATE

I certify that having read this entire form, including the information on the reverse and (1) I understand and agree to its terms and (2) I apply for enrollment and/or waive group benefits and (3) the information I have provided is accurate and complete.

X EMPLOYEE'S SIGNATURE DATE



EMPLOYEE APPLICATION

Please read the following carefully. Once signed on the reverse, and accepted, this application including all enrollment forms become a part of the BCBSAZ contract with your employer group. If you have any questions concerning this information, please talk with your group's health plan administrator or your BCBSAZ service representative.

#### ACKNOWLEDGMENTS, AGREEMENTS AND AUTHORIZATIONS

- A. I have carefully read the entire application and have been given information that explains the terms and conditions of this coverage. On behalf of myself and the persons listed on this application as eligible dependents, I apply for enrollment and/or waive group benefits subject to all terms and conditions of this coverage offered by my employer. I understand this application includes any enrollment forms I complete when applying for this coverage, including any Risk Evaluation Form. I understand this entire application becomes a part of my group's contract with BCBSAZ.
- B. To the best of my knowledge, the information provided with this application is complete and accurate. I understand the information provided with this application is material to BCBSAZ and BCBSAZ will rely on this information to determine my employer group's eligibility for BCBSAZ coverage and/or to establish group premium rates.
- C. I understand BCBSAZ does not underwrite or guarantee any separate life and/or disability insurance that may be offered by my employer group health plan.
- D. I acknowledge and agree coverage shall become effective only when BCBSAZ: (1) reviews and accepts this application and (2) issues coverage to my employer group and me on effective dates assigned by BCBSAZ.
- E. If any part of the premium for this coverage is to be met through payroll deduction, I authorize my employer to deduct periodically from my wages and remit to BCBSAZ amounts necessary to continue coverage.
- F. I understand the contract between my employer group and BCBSAZ controls the administration of this group coverage. Coverage is subject to change upon notification to my employer group. My employer is responsible for notifying me of all changes, including termination of the employer group contract by (1) the group or (2) BCBSAZ for non-payment of premiums by the group. Upon termination of the employer group contract, I understand I may be eligible for other coverage with BCBSAZ as required under state and/or federal law.
- G. I understand that if, BCBSAZ, its reinsurers, and their authorized representatives need to obtain medical information to evaluate my application and/or for claims processing, I am responsible for any costs associated with obtaining such medical information. Personal information may be collected from someone other than me or one of the proposed covered persons.
- H. I understand if I am declining enrollment for myself or my dependents (including my spouse) because of other health/dental coverage, it may be possible in the future to enroll me and/or my dependent(s) in this BCBSAZ group health/dental coverage, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement of adoption, I may be able to enroll my dependent, provided that I request enrollment within 31 days after marriage, birth, adoption or placement of adoption.
- I. By including my e-mail address on the reverse side, I am authorizing Blue Cross Blue Shield of Arizona (BCBSAZ) to send me information via e-mail. You may change your e-mail address or rescind this permission at any time by contacting BCBSAZ through [www.azblue.com](http://www.azblue.com).

#### Reason Codes for Declining/Waiver Coverage

(subject to BCBSAZ's Group Underwriting Participation Guidelines)

A - Does not wish to be covered – no other coverage  
B - Covered by spouse's or parents' employer group plan  
C - Covered by TRICARE  
D - Covered by AHCCCS

E - Covered by IHS (Indian Health Services)  
F - Covered by Medicare  
G - Married Co-Workers  
H - Individual Coverage