

EMPLOYEE ENROLLMENT / WAIVER

BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402-2555
www.bcbst.com



EEW-05

Plan Use Only
Rec: _____

PLEASE USE BLUE OR BLACK INK ONLY
IF YOU ARE DECLINING COVERAGE, PLEASE GO TO BACK OF FORM.

- CONFIDENTIAL -

Section 1 - Group / Employer Information. This form cannot be processed without this information.

GROUP NO. _____ SUBGROUP NO. _____ DEPARTMENT NO. _____ GROUP NAME _____

COVERAGE EFFECTIVE DATE: _____

Medical: _____ Dental: _____

NEW ENROLLMENT (CHECK IF APPLICABLE):

New Hire Open Enrollment Rehire Part-time change to Full-time Full-time / Rehire Date: _____

Hrs Wkd/Wk _____

QUALIFYING EVENT:

Marriage New Dep Child Loss of Other Medical Cvg Loss of Other Dental Cvg Court Order

Event Date: _____

COBRA OR STATE CONTINUATION:

Termination of Employment (Voluntary or Involuntary) Employee Eligible for Medicare Reduction in Hours

Dependent Child No Longer Eligible Divorce / Legal Separation Death of Employee

Other: _____

Section 2 - Employee / Member Information. Employee Must Complete in Full.

ELECT: Medical Option: 1 2 3 4 Other _____

ELECT: Dental Option: 1 2 3 4 Other _____

(1) EMPLOYEE LAST NAME _____ EMPLOYEE FIRST NAME _____ MI _____ JR., SR., ETC. _____ SOCIAL SECURITY NO. * _____

ADDRESS _____

CITY (Please do not abbreviate) _____ STATE _____ ZIP _____

DATE OF BIRTH _____

Male Female

JOB TITLE _____

HICN _____

PAID CLASSIFICATION

Hourly Salary Retiree Surviving Spouse

JOB CLASSIFICATION

Management Non-Management Exec/Officer/Owner

PAYROLL NO. _____

OTHER INSURANCE

If you or listed dependents will be covered by other health, dental or Medicare insurance when this plan goes into effect, indicate which coverage. Medical/Medicare Dental

HAVE YOU HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?

Section 3 - Dependent Information. Please provide all information for each person to be covered. LIST ADDITIONAL DEPENDENTS ON BACK. Consult Employer Guidelines for Dependent Eligibility.

(2) SPOUSE LAST NAME _____ SPOUSE FIRST NAME _____ MI _____ JR., SR., ETC. _____ DATE OF BIRTH _____

Male Female

DATE OF BIRTH _____

Male Female

Physically Handicapped Fulltime Student Over 19

SOCIAL SECURITY NO. * _____

From: _____ To: _____

HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?

(3) DEPENDENT LAST NAME _____ DEPENDENT FIRST NAME _____ MI _____ JR., SR., ETC. _____ DATE OF BIRTH _____

Male Female

Physically Handicapped Fulltime Student Over 19

SOCIAL SECURITY NO. * _____

From: _____ To: _____

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? YES NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE?

Section 4 - Acknowledgment. Signature and Date MUST BE COMPLETED.

Employee's Signature: _____ X _____ Date: _____

Daytime Contact No.: _____ (Area Code) _____

Employee should notify BlueCross BlueShield of Tennessee if any dependent's address is different from the employee's address. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage. I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract and that; 3) I am responsible for any fee for these records.

SPANISH IS MY PRIMARY HOUSEHOLD LANGUAGE

* To comply with Federal regulations we must have Social Security Number

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APP-EEW (7/06)

