

www.BlueChoiceSC.com

New Enrollment <input type="checkbox"/> Effective Date: _____	Change <input type="checkbox"/> Effective Date: _____	Product – Advantage <input type="checkbox"/> Advantage Plus <input type="checkbox"/> BlueChoice POS <input type="checkbox"/> Primary Choice <input type="checkbox"/>	<input type="checkbox"/> Low Option <input type="checkbox"/> High Option <input type="checkbox"/> HDHP
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A. COMPLETE IF MAKING A CHANGE

ENROLLMENT CHANGE DUE TO:

<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Termination	<input type="checkbox"/> COBRA Applicant	<input type="checkbox"/> Divorce	GRP #: _____ _____
<input type="checkbox"/> Death	<input type="checkbox"/> Physician Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other _____		

B. TO BE COMPLETED BY ALL EMPLOYEES

1. Employee Actively At Work <input type="checkbox"/>	COBRA <input type="checkbox"/>	Retired <input type="checkbox"/>	TYPE OF CONTRACT			
			<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Employee/Spouse/Children

2. Social Security No.	3. Employee – Last Name	First	Middle Initial	Date of Birth	Sex: Male <input type="checkbox"/>
					Female <input type="checkbox"/>

4. Mailing Address	Street or P.O. Box	City	State	ZIP Code
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5. Home Phone	Work Phone	6. E-Mail Address:
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7. Name of Employer:	8. Date of Hire:	9. Dept. No.:
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C. COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Please list all family members to be enrolled or affected by the change. Do not use nicknames. Student verification is required for children who are older than the eligible age for dependent children.

Last Name	First	Initial	Sex	Date of Birth Mo. Day Yr.	Social Security Number
YOURSELF:					
Spouse/Partner:					
Child:					
Child:					
Child:					
Child:					

D. OTHER INSURANCE INFORMATION

Are you, your spouse or dependents covered by Medicare or any other health insurance? Yes No If No, do not complete this section.

Name of Person Covered	Name of Health Insurance Co.	Policy # / HIC #	Eff. Date	Policyholder's Employer

E. COMPLETE FOR LIFE AND/OR DISABILITY Coverage provided by Companion Life Insurance Company

Companion Life is a separate life insurance company that does not provide BlueChoice HealthPlan products or services. Companion Life is solely responsible.

<p><small>Types and Amounts of Life Insurance Coverage Desired</small></p> <input type="checkbox"/> Life _____ Supplemental <input type="checkbox"/> AD&D _____ <input type="checkbox"/> Life _____ <input type="checkbox"/> Dep. Life _____ <input type="checkbox"/> AD&D _____ <input type="checkbox"/> STD _____ <input type="checkbox"/> Dep. Life _____ <input type="checkbox"/> LTD _____	<p>Earnings (Check One) <input type="checkbox"/> Biweekly \$ _____ <input type="checkbox"/> Hourly (Amount) <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually</p>	<p>Life Class _____</p>
Full Name (Last Name, First, Init.): _____ Relationship _____		
Primary Beneficiary(ies): _____		
Contingent Beneficiary(ies): _____		
SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION		

F. COMPLETE FOR DENTAL COVERAGE Coverage provided by BlueCross BlueShield of South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

Dental Coverage Is For: Employee Employee/Spouse Employee/Children Employee/Spouse/Children

Are you covered by other dental insurance? Yes No If spousal coverage is requested, is your spouse covered by other dental insurance? Yes No

G. EMPLOYEE STATEMENT OF UNDERSTANDING

I have read the back of this form and agree. I have read and understand each and every part of this form.

SIGNATURE: _____ DATE: _____

INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

- A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).
- B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.
- C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.
- D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.
- E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION APPLIES TO BLUECHOICE HEALTHPLAN MEDICAL BENEFITS ONLY

This plan may contain a pre-existing condition exclusion. This means that if you have a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date, you might have to wait a certain period of time before that plan will provide coverage for that condition. This six-month period ends the earlier of the day before your coverage becomes effective (the effective date) or if you were in a waiting period for coverage, the day before the waiting period begins (the enrollment date). The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

BlueChoice HealthPlan
Members Services Department
Post Office Box 6170
Columbia, SC 29260-6170
Or Call
1-800-868-2528
or 803-382-5025 in Columbia

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical or non-medical information about me or my enrolled dependents by any insurance company, medical institution or other health care provider. This authorization for release of my (our) information, to include Medicare claims, is for eligibility determination or review/investigation of a claim filed with BlueChoice HealthPlan.

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.