Application for Coverage

CLAIMS SUPERVISOR

BlueCross BlueShield of Wyoming
An independent licensee of the Blue Cross and Blue Shield Association

❑ Initial Enrollment ❑ Decline Coverage(s)
❑ Add or q Remove Dependent(s) to Existing Coverage
q Change Status to RETIREE
q Other Change (please explain)_____

PLEASE COMPLETE IN FULL, EVEN IF ADDING NEWBORN.

Date of Marriage (if Applicable) ____/____/____

Date Dependent Was Acquired ____/____/____
(Date of Birth, Adoption, etc.)

Please print, using black ink, and initial all corrections; do not use correction fluid or correction tape.

Section 1. EMPLOYEE INFORMATION

NAME OF EMPLOYEE (First) (M.I.) (Last)	HOME TELEPHONE	WORK TELEPHONE	MARITAL STATUS ☐ Married ☐ Single
MAILING ADDRESS	CITY STATE ZIP		
EMPLOYER NAME		DATE EMPLOYED FULL TIME	
EMAIL ADDRESS			

Section 2. ENROLLMENT INFORMATION

RELATIONSHIP	FAMILY MEMBER'S NAME – List all family members to be covered (attach additional page if necessary) (Last) (First) (MI)	SEX	DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY #
EMPLOYEE				
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

Section 3. DECLINATION INFORMATION

I am declining health coverage under my employer's self-funded plan on behalf of the following (print name for all individuals for whom you are declining):

NAME	RELATIONSHIP	SOCIAL SECURITY #	IS THIS INDIVIDUAL COVERED ELSEWHERE? If Yes, Complete Section 4. NO	YES

I have had the Enrollment Regulations of my employer's health plan explained to me and I understand if I delay in making application until after the initial period of eligibility I and/or my dependents will be subject to the late enrollee provisions as stated in my employer's Benefit Document unless I and/or my eligible dependents qualify for a special enrollment period as provided by applicable law.

Signature:_____ Date:_____

For Blue Cross Blue Shield Office use Only
Class_____ **GRP/Roll**_____ **AD**_____ **Probationary Period**_____

OED_____ **BCBS**_____ **DSC**_____

Section 4. REQUIRED INFORMATION RELATED TO HEALTH COVERAGE

Please complete the following for ALL individuals named on this application who currently have, or who had in the past year, other health coverage. Attach extra pages which you have signed and dated, if necessary. If there is no other existing or prior coverage, please indicate by writing "NONE."

Policyholder's Name: _____ Covered Individuals: _____

Name of Insurance Company: _____ Insurance Company Address: _____

Policy #: _____ Coverage Began (MM/DD/YYYY): _____ Ended (MM/DD/YYYY): _____

Name of Employer: _____

If still in effect, will the coverage described above be cancelled when this Blue Cross Blue Shield of Wyoming coverage becomes effective?
☐ Yes ☐ No

If no longer in effect, did the coverage described above terminate for ANY of the following reasons: Termination of employment; Termination of the employer's contribution to coverage; Termination of the other health plan's coverage with the employer; Death of a spouse; Divorce or Legal Separation; Loss of Medicaid or KidCare CHIP Coverage? ☐ Yes ☐ No

If yes, please list reason for termination: _____

Section 5.

A. I understand that upon acceptance of this application, coverage will become effective on the date established by my employer.

B. I affirm that I have reviewed all answers given on this application and, regardless of whether any other individual has filled out the answers for me; I verify that the answers are true and complete. I REALIZE THAT ANY ACT, PRACTICE, OR OMISSION I HAVE PERFORMED THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT ASKED FOR ON THIS APPLICATION WILL RENDER THE CONTRACT NULL AND VOID OR SUBJECT TO CANCELLATION, RESCISSION, OR TO DISALLOWANCE OF THE INDIVIDUAL ABOUT WHICH THE FRAUDULENT ACT, PRACTICE, OMISSION, OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT OCCURRED.

I HAVE READ AND I UNDERSTAND ITEMS A - B ABOVE. I hereby apply for coverage for myself and/or my dependent(s) listed in Section 2. under the terms and conditions as stated in my employer's Benefit Document.

SIGN BELOW ONLY IF YOU ARE APPLYING FOR COVERAGE.

APPLICANT'S SIGNATURE _____ DATE _____

APPLICATION WILL NOT BE PROCESSED IF RECEIVED MORE THAN 60 DAYS AFTER DATE OF SIGNATURE

IMPORTANT: Please be certain you have answered ALL questions on this application.