

ENROLLMENT FORM

EMPLOYMENT AND COVERAGE INFORMATION

NAME OF EMPLOYER	GROUP #	TYPE OF COVERAGE	BENEFIT PLAN SELECTED	EFFECTIVE DATE	IS THIS A LATE ENROLLMENT*
		<input type="checkbox"/> SINGLE MEDICAL <input type="checkbox"/> FAMILY MEDICAL <input type="checkbox"/> SINGLE DENTAL <input type="checkbox"/> FAMILY DENTAL <input type="checkbox"/> SINGLE COBRA <input type="checkbox"/> FAMILY COBRA <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STANDARD <input type="checkbox"/> PCN/PPO <input type="checkbox"/> PCN <input type="checkbox"/> PPO		<input type="checkbox"/> YES <input type="checkbox"/> NO

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	M.I.	BIRTH DATE			SEX	DATE OF HIRE			SOCIAL SECURITY NUMBER				SELECTED PCN PHYSICIAN*	FOR EMPLOYER USE ONLY
			MO.	DAY	YR.	M/F	MO.	DAY	YR.						PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE

Are you a current, active employee? Yes No If No, retirement date: _____

CURRENT MAILING ADDRESS

STREET OR P.O. BOX	CITY	STATE	ZIP CODE	COUNTY

COMPLETE FOR FAMILY COVERAGES ONLY:

EMPLOYEE AND SPOUSE		EMPLOYEE AND CHILDREN				EMPLOYEE AND FAMILY				FOR EMPLOYER USE ONLY				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>								
LAST NAME	FIRST NAME	M.I.	DEPENDENT SOCIAL SECURITY NO.			BIRTH DATE			SEX	RELATIONSHIP TO EMPLOYEE	**FULL-TIME STUDENT	HANDICAPPED	SELECTED PCN PHYSICIAN*	PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE
						MO.	DAY	YR.	M/F					

**NAME OF ACCREDITED COLLEGE OR UNIVERSITY _____ SEMESTER FOR WHICH STUDENT IS ENROLLED _____ NUMBER OF HOURS ENROLLED PER SEMESTER _____

OTHER INSURANCE INFORMATION

Spouse's Employer: _____ Do you or any member of your family have other health/dental insurance? Yes No Medicare Blue Cross/Blue Shield
 Spouse's Date of Birth: _____ If Medicare, reason for coverage: Over 65 Disabled Kidney Disease Medicare effective date: _____

If yes, please indicate: Policy Holder _____ Policy # _____ Type of Coverage: **Medical** **Dental**
 Insurance Co. Name _____ Single Single
 Insurance Co. Address _____ Family Family

IMPORTANT: ALL APPLICATIONS MUST BE SIGNED

PLEASE SIGN BELOW:

I hereby authorize any providers of health care services, claim administrators, insurers, reinsurers, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about my health status and health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original. I also release to BlueAdvantage Administrators of Arkansas any and all information relative to Title XVIII Medical Claims, or claims with other benefit plans or insurance companies, by or on behalf of me or any covered member of my family, in order to coordinate benefits with this plan.

If you are enrolling in a PCN program:

I have read and understand the material provided explaining The Primary Care Network and have elected to enroll in this program. I understand that no PCN services (except life threatening or unless otherwise specified by your plan document) will be covered without being authorized by the Primary Care Physician listed on this application for myself and any eligible family members. I further recognize that I have the right to voluntarily change primary care physicians participating in The Primary Care Network without losing the additional benefits available under this program. I understand that should I, or a family member covered under my contract, fail to adhere to the provisions of the Primary Care Network Program, I could be forced to return to the standard benefits program offered through my employer or be forced to encounter additional out-of-pocket expense due to reduced benefit payment.

I further authorize payment direct to my primary care physician, referred physician, hospital or other medical provider for the medical benefits otherwise payable to me.

I understand that all determinations affecting the quality of medical care will be solely between myself and my physicians.

EMPLOYEE SIGNATURE _____ EMPLOYER SIGNATURE _____ *ENROLLMENT DATE _____