BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 1460
Little Rock, Arkansas 72203-1460

# ENROLLMENT FORM

## EMPLOYMENT AND COVERAGE INFORMATION

| NAME OF EMPLOYER | GROUP # | TYPE OF COVERAGE | BENEFIT PLAN SELECTED | EFFECTIVE DATE | IS THIS A LATE ENROLLMENT* |
|---|---|---|---|---|---|
| | | ☐ SINGLE MEDICAL ☐ FAMILY MEDICAL<br>☐ SINGLE DENTAL ☐ FAMILY DENTAL<br>☐ SINGLE COBRA ☐ FAMILY COBRA<br>☐ OTHER___ | ☐ STANDARD ☐ PCN/PPO<br>☐ PCN ☐ PPO | | ☐ YES ☐ NO |

## EMPLOYEE INFORMATION

| LAST NAME | FIRST NAME | M.I. | BIRTH DATE | | | SEX | DATE OF HIRE | | | SOCIAL SECURITY NUMBER | SELECTED PCN PHYSICIAN* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | MO. | DAY | YR. | M/F | MO. | DAY | YR. | | |
| | | | | | | | | | | – – | |

FOR EMPLOYER USE ONLY: 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 ☐

| LAST NAME | FIRST NAME | M.I. | DEPENDENT SOCIAL SECURITY NO. | BIRTH DATE | | | SEX | RELATIONSHIP TO EMPLOYEE | **FULL-TIME STUDENT | HANDI-CAPPED | SELECTED PCN PHYSICIAN* | FOR EMPLOYER USE ONLY: PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | MO. | DAY | YR. | M/F | | | | | |
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**NAME OF ACCREDITED COLLEGE OR UNIVERSITY ___ SEMESTER FOR WHICH STUDENT IS ENROLLED___ NUMBER OF HOURS ENROLLED PER SEMESTER___

## OTHER INSURANCE INFORMATION

Spouse's Employer:
Spouse's Date of Birth:

Do you or any member of your family have other health/dental insurance? ☐ Yes ☐ No ☐ Medicare ☐ Blue Cross/Blue Shield
If Medicare, reason for coverage: ☐ Over 65 ☐ Disabled ☐ Kidney Disease Medicare effective date:___

If yes, please indicate: Policy Holder___ Policy #___
Insurance Co. Name___
Insurance Co. Address___

Type of Coverage: ☐ **Medical** ☐ Single ☐ Family ☐ **Dental** ☐ Single ☐ 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___

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