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 ☐ SINGLE DENTAL ☐ FAMILY DENTAL ☐ SINGLE COBRA ☐ FAMILY COBRA ☐ OTHER____________	☐ STANDARD ☐ PCN/PPO ☐ 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					

**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____________

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.