Enrollment and Change Form

BlueCross BlueShield of Oklahoma

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to us unless the group is self-administered. If the group is self-administered, submit enrollment forms to us only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION			
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	SEX ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.	EARNINGS Weekly ☐ Monthly ☐ Annual ☐	JOB TITLE	CLASS		
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE	WORK PHONE	CELL PHONE			
SPOUSE NAME (if Applicant) - LAST	FIRST	M.I.	SEX ☐ M ☐ F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

Has the Employee (if applying) used **any** tobacco products in the last 2 years?	☐ Yes	☐ No
Has the Spouse (if applying) used **any** tobacco products in the last 2 years?	☐ Yes	☐ No

BENEFIT SELECTION - Life, Disability, Critical Illness, Accident, Hospital Indemnity & AD&D

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your Employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

☐ Term Life / AD&D	☐ Short-Term Disability (STD)	☐ Long-Term Disability (LTD)
☐ Dependent Term Life / AD&D	☐ Critical Illness ☐ Spouse ☐ Child(ren)	☐ Accidental Death and Dismemberment (AD&D)
☐ Accident ☐ Spouse ☐ Child(ren) ☐ Family	☐ Hospital Indemnity ☐ Spouse ☐ Child(ren) ☐ Family	

Supplemental Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life / AD&D	Employee			
☐ Term Life / AD&D	Spouse			
☐ Term Life / AD&D	Child(ren)			
☐ Critical Illness	Employee			
☐ Critical Illness	Spouse			
☐ Critical Illness	Child(ren)			
☐ AD&D	Employee			
☐ AD&D	Spouse			
☐ AD&D	Child(ren)			

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Voluntary Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life	Employee			
☐ Term Life	Spouse			
☐ Term Life	Child(ren)			
☐ AD&D	Employee			
☐ AD&D	Spouse			
☐ AD&D	Child(ren)			
☐ AD&D	Dependents			
☐ AD&D	☐ Employee ☐ Family			
☐ Long-Term Disability (LTD): Incremental				
☐ Long-Term Disability (LTD): % of Earnings				
☐ Short-Term Disability (STD): Incremental				
☐ Short-Term Disability (STD): % of Earnings				
☐ Critical Illness	Employee			
☐ Critical Illness	Spouse			
☐ Critical Illness	Child(ren)			
☐ Accident	Employee			
☐ Accident	Employee + Spouse			
☐ Accident	Employee + Child(ren)			
☐ Accident	Family			
☐ Hospital Indemnity	Employee			
☐ Hospital Indemnity	Employee + Spouse			
☐ Hospital Indemnity	Employee + Child(ren)			
☐ Hospital Indemnity	Family			

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

	First Name	Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary						%
Primary						%
Contingent						%
Contingent						%

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BENEFIT SELECTION ☐ DENTAL ☐ VISION

ENROLLMENT	POLICY CHANGE	CANCEL COVERAGE
Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate. *(Choose One)*	*(Check Reason for Change)*	
☐ Employee	☐ Married	☐ Terminate Coverage Date ________
☐ Employee + Spouse	☐ Birth / Adoption	☐ Leave / Layoff
☐ Employee + Child(ren)	☐ Widowed	☐ Other
☐ Family	☐ Divorced	Date ________
	☐ Address Change	

If above selection covers your Spouse, is your Spouse covered under any other dental plan? ☐ Yes ☐ No

If Yes, carrier's name:

COBRA CONTINUATION PRIVILEGE

Start Date: ____________

Projected End Date: ____________

Previously covered with group as:

☐ 1. Employee (termination, reduction in hours, other)

☐ 2. Spouse (divorce from Employee, death of Employee)

☐ 3. Dependent (reached age limit, married, no longer a Full Time Student, other)

☐ 4. Spouse & Dependents (divorce from Employee, death of Employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law of provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name	Last Name	Social Security Number	Date of Birth	Relationship	SEX	Adult Child FTS or HDCP	Name of Accredited School
				SPOUSE	☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		
					☐ M ☐ F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the Employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR OFFICE USE ONLY

EMPLOYEE SIGNATURE ______________________ DATE ____________

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE ______________________ DATE ____________

Fraud Notices

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The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.