



BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. ® Registered Marks Blue Cross Blue Shield Association.

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Blue Cross and Blue Shield of Oklahoma

BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. ® Registered Marks Blue Cross Blue Shield Association.

FOR OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE
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APPLICATION for MEMBERSHIP

RETURN THIS FORM TO:

Blue Cross and Blue Shield of Oklahoma • Enrollment Services • P.O. Box 3283 • Tulsa, Oklahoma 74102-3283

TELL US WHO YOU WANT TO ENROLL FOR HEALTH BENEFITS COVERAGE (CHECK ONE BOX)

<input type="checkbox"/> EMPLOYEE ONLY PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 7 AND 10 THROUGH 12	<input type="checkbox"/> EMPLOYEE AND SPOUSE PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 8 AND 10 THROUGH 12	<input type="checkbox"/> EMPLOYEE AND UNMARRIED CHILDREN PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 7 AND 9 THROUGH 12	<input type="checkbox"/> EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 12
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TELL US WHAT TYPE COVERAGE YOU CHOOSE (CHECK ONE BOX)

1 BLUELINCS HMO <input type="checkbox"/>	BLUEPREFERRED <input type="checkbox"/>	BLUECHOICE <input type="checkbox"/>	BLUETRADITIONAL <input type="checkbox"/>	BLUEOPTIONS <input type="checkbox"/>	HSA BLUE <input type="checkbox"/>
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TELL US ABOUT YOURSELF (PLEASE PRINT IN INK OR TYPE)

2 NAME OF APPLICANT (EMPLOYEE) (LAST, FIRST, MIDDLE) _____ RESIDENCE TELEPHONE A/C _____

3 (STREET OR BOX NO.) _____ (CITY) _____ (STATE) _____ (9-DIGIT ZIP CODE) _____

4 SOCIAL SECURITY NUMBER _____ DATE OF BIRTH MO. DAY YR. _____ SEX M F MARITAL STATUS MARRIED DIVORCED WIDOWED SINGLE SEPARATED BUSINESS PHONE A/C _____

5 I AM EMPLOYED BY (COMPANY, CITY, STATE) _____ HOW MANY HOURS PER WEEK DO YOU WORK? _____ DATE EMPLOYED FULL-TIME MO. DAY YR. _____ EMPLOYER GROUP NO. (TO BE COMPLETED BY EMPLOYER FOR SUBSEQUENT HIRES) _____

6 DOES ANYONE LISTED ON THIS APPLICATION HAVE HEALTH INSURANCE, MEDICARE OR MEDICAID, OR HAS ANYONE LOST COVERAGE DURING THE LAST 2 MONTHS? YES NO IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME _____

INSURED'S NAME _____ MEMBER ID/SUBSCRIBER NO./CASE NO. _____ GROUP NO./POLICY NO. _____ PERSONS COVERED APPLICANT SPOUSE DEPENDENTS LISTED ON APPLICATION OTHER _____

HAS COVERAGE TERMINATED? YES, ON ____/____/____ NO IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED? YES, CURRENT COVERAGE WILL BE TERMINATED NO, I WILL KEEP BOTH COVERAGES **NOTE: IF MORE THAN (1) ONE INSURANCE POLICY, PLEASE PROVIDE THE INFORMATION ON ITEM 6 FOR ADDITIONAL INSURANCE CARRIERS ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THIS APPLICATION.**

7 IF YOU HAVE SELECTED BLUELINCS HMO OR BLUEPREFERRED W/PCP, THE FOLLOWING INFORMATION IS REQUIRED: EMPLOYEE'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) _____ IS THIS YOUR CURRENT PHYSICIAN YES NO PCP NUMBER FROM PROVIDER DIRECTORY **PCP-** _____

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GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVA CODE	W/C EFF. DATE	W/C EXP DATE	PROD. CODE	DIVISION CODE	CROSS REFERENCE AGREEMENT NO.
COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	SUB CHAR.	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP. DENT. CHAR.
LOB	LOB	LOB	LOB	LOB	LOB	LOB	SPECIAL NOTES	CODED BY

PLEASE TURN THE PAGE

10.127 (8/04)

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- **NOTICE:** You are considered a Timely Enrollee if your application is received by the Plan within 31 days of your eligibility period (when any group initially enrolls or as a new hire upon completion of a waiting period, if any, as specified in the group contract). If you are declining enrollment for your spouse or your dependents because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependents in this plan provided you request Special enrollment within 31 days after the other coverage ends. Qualifying events for this Special enrollment include termination of employment, reduction of work hours, legal separation, divorce, death, employer contributions toward the other coverage have terminated, or COBRA or state continuation of coverage has been exhausted. If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself, your spouse, and your dependents, provided you request Special enrollment within 31 days of the event and provide documentation showing the date of the event. If you do not enroll upon the initial offering of this coverage (Timely Enrollee) or do not enroll as a Special Enrollee, you, your spouse and/or your dependent may apply during the Open Enrollment period (31 days prior to your group's renewal date) as a Late Enrollee.
- There is a Preexisting Condition limitation on the coverage available from the Plan (except for BlueLincs HMO coverage). A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. A Preexisting Condition will not apply to pregnancy or to a newborn or adopted child under age 18, provided the child becomes covered under the Contract/Agreement within 31 days of birth or adoption. The length of the Preexisting Condition limitation period is 12 months after the enrollment date for Timely and Special Enrollees, and 18 months for Late Enrollees. The Preexisting Condition limitation waiting period may be reduced by the number of days you (and/or your spouse, and/or dependents) were covered under a prior health insurance plan(s) should there be no more than a 63-day break in coverage, excluding your waiting period, if any. To do this you may request a Certificate of Coverage form from the prior health plan(s) or issuer and send it to our Enrollment Services department. After the amount of prior creditable coverage has been determined, we will notify you of Preexisting Condition credit based on your prior coverage. Please attach your Certificate of Coverage, if you currently have one.

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● **AGREEMENTS AND SIGNATURES (PLEASE READ, SIGN AND DATE)**

I, on behalf of myself and any persons whose names appear on this application, hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma or BlueLincs HMO (herein called the "Plan") as stated in this application. I agree that if my application is accepted, coverage will be effective on the effective date assigned by the Plan. I further agree that any changes in my coverage will not become effective until approved by the Plan. I understand that this is an application only, and I should not cancel any existing coverage until I am notified of acceptance, in writing, by the Plan. If I have selected Blue Cross and Blue Shield of Oklahoma coverage, I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma and to vote in my name upon any matters arising at said meetings. However, I retain the right to vote at any and all meetings of the members.

- I have read all the statements and notices on this application and represent that those items are true and complete to the best of my knowledge and belief. I know that any material misstatements or omissions of information that are made on this application may be the basis for later withdrawal of insurance coverage or denial of a loss incurred during my or my dependent's coverage. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the Plan.
- I understand that if my application is being handled through a broker or agent, I authorize that broker or agent to receive and review my application, which may contain medical information about me or other family members listed on this application.

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SIGNATURE OF APPLICANT (EMPLOYEE) I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED
MO. | DAY | YR.

SIGNATURE OF SPOUSE I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED
MO. | DAY | YR.

X

X