

Personal Blue

APPLICATION for ENROLLMENT



BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.
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 www.bcbsok.com

RETURN THIS FORM TO:

Blue Cross and Blue Shield of Oklahoma • **ATTN: ENROLLMENT SERVICES** • P.O. Box 3283 • Tulsa, OK 74102-3283

TELL US WHO YOU WANT TO ENROLL (CHECK ONE BOX)

<input type="checkbox"/> APPLICANT ONLY <small>COMPLETE ITEMS 1 THROUGH 5 & 8</small>	<input type="checkbox"/> APPLICANT AND SPOUSE <small>COMPLETE ITEMS 1 THROUGH 6 & 8</small>	<input type="checkbox"/> APPLICANT AND UNMARRIED CHILDREN <small>COMPLETE ITEMS 1 THROUGH 5, 7 & 8</small>	<input type="checkbox"/> EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN <small>COMPLETE ITEMS 1 THROUGH 8</small>
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1. TELL US HOW YOU WANT TO BE BILLED: BANK DRAFT* OR DIRECT BILL (CHECK ONE)
 MONTHLY OR QUARTERLY (CHECK ONE) **OPTION FOR** 1ST OR 15TH OF EVERY MONTH (CHECK ONE)

2. APPLICANT INFORMATION

NAME OF APPLICANT (LAST)	(FIRST)	(MIDDLE)	RESIDENCE TELEPHONE A/C	BUSINESS PHONE A/C
YOUR HOME ADDRESS (STREET OR BOX NO.)			(CITY)	(STATE)
			(9-DIGIT ZIP CODE)	
SOCIAL SECURITY NUMBER		DATE OF BIRTH MO. DAY YR.	SEX M F	MARRIAGE DATE MO. DAY YR.
			<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
			<input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED	

3. EMPLOYMENT INFORMATION

I AM EMPLOYED BY (COMPANY, CITY, STATE)	I CURRENTLY WORK 24 OR MORE HOURS A WEEK <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE EMPLOYED FULL-TIME MO. DAY YR.
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4. PRESENT HEALTH COVERAGE INFORMATION

DO YOU NOW HAVE BLUE CROSS AND BLUE SHIELD? <input type="checkbox"/> YES <input type="checkbox"/> NO	BCBS AGREEMENT NO. (SUBSCRIBER ID NO.)	YOUR BCBS GROUP NO.	LOCATION OF BCBS PLAN CITY STATE
I REQUEST THAT MY COVERAGE BE CONVERTED TO PERSONAL BLUE DUE TO THE FOLLOWING EVENT:			
<input type="checkbox"/> 1. TERMINATION OF GROUP COVERAGE MO. DAY YR. DATE	<input type="checkbox"/> 2. DEATH OF THE EMPLOYEE MO. DAY YR. DATE	<input type="checkbox"/> 3. DIVORCE OR LEGAL SEPARATION FROM THE EMPLOYEE MO. DAY YR. DATE	<input type="checkbox"/> 4. DEPENDENT CHILD CEASES TO MEET THE GROUP CONTRACT DEFINITION OF "DEPENDENT" MO. DAY YR. DATE
5. ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED BY ANY OTHER GROUP HEALTH INSURANCE OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST OTHER GROUP NUMBER	POLICY NUMBER	NAME OF POLICY HOLDER

6. SPOUSE INFORMATION

NAME OF SPOUSE (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER	EMPLOYED BY (NAME OF COMPANY)	I CURRENTLY WORK 24 OR MORE HOURS A WEEK: <input type="checkbox"/> YES <input type="checkbox"/> NO
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7. DEPENDENT INFORMATION - IF MORE ROOM IS NEEDED FOR DEPENDENTS, USE ANOTHER APPLICATION FORM

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT <input type="checkbox"/> SON/STEP-SON <input type="checkbox"/> DAUGHTER/STEP-DAUGHTER <input type="checkbox"/> OTHER (DESCRIBE)	DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO.	IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT <input type="checkbox"/> SON/STEP-SON <input type="checkbox"/> DAUGHTER/STEP-DAUGHTER <input type="checkbox"/> OTHER (DESCRIBE)	DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO.	IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO APPLICANT <input type="checkbox"/> SON/STEP-SON <input type="checkbox"/> DAUGHTER/STEP-DAUGHTER <input type="checkbox"/> OTHER (DESCRIBE)	DATE OF BIRTH MO. DAY YR.
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	IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVR CODE	W/C EFF. DATE	W/C EXP DATE	CROSS REFERENCE AGREEMENT NO.
COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	SUB CHAR.	DEP. CHAR.	LOB
						EFFECTIVE DATE.

*If you selected "Bank Draft" in Section 1., see reverse to complete "Financial Institution Information"

8. AGREEMENT 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 (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 Blue Cross and Blue Shield of Oklahoma.
- 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 attend and 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 and 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 any physician, medical practitioner, hospital, clinic, Veterans Administration facility, or other medical or medically related facility, insurance or reinsurance company, HMO, the Medical Information Bureau, Inc., or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my covered dependents, and any other non-medical information of me or my covered dependents to give to the Plan or their legal representative any and all such information. I understand the information obtained by use of this authorization may be used by the Plan to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by the Plan to any person or organization, except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize. I know that I may request a photographic copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. *I further understand and acknowledge that, in accordance with 63 O.S., Section 1.502.2, as amended, the information authorized for release may include information which may be considered a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis and gonorrhea, and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).*
- I understand that this contract is subject to the same preexisting conditions limitations, if any, as the policy from which I am converting, but in no event will such limitation exceed 12 months following my Effective Date of coverage under this contract.
- I understand that this contract is subject to the same preexisting conditions limitations, if any, as the policy from which I am converting, but in no event will such limitation exceed 12 months following my Effective Date of coverage under this contract.
- I understand that this contract is subject to the same maternity waiting period, if any, as the policy from which I am converting. If the prior policy did not include maternity benefits, then coverage under this contract must be in effect for 365 days prior to delivery before maternity benefits will be available to the member or covered spouse.
- This application when processed may result in denial, exclusion, or limitation of coverage.
- I have read all the statements on this application and represent that they are true and complete to the best of my knowledge and belief. I understand that any false or incomplete information can result in retroactive cancellation of membership and coverage for all persons under the membership, and I will be obligated to repay promptly any benefit payments to which persons covered under the membership were not entitled. Blue Cross and Blue Shield of Oklahoma may also recoup any monies paid as benefits prior to a determination by the Plan that any medical condition(s) or other information required to be reported was not correctly represented.

SIGNATURE OF APPLICANT - I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED

SIGNATURE OF APPLICANT - I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED

FINANCIAL INSTITUTION INFORMATION

IMPORTANT: If you select the Bank Draft option in Section 1., payments will be automatically deducted from your personal bank account. Complete this authorization and attach a voided check in the space below.

As a convenience to me, I hereby authorize BLUE CROSS AND BLUE SHIELD OF OKLAHOMA to initiate debit entries from my account when the payment is due.

FINANCIAL INSTITUTION NAME

CITY

STATE

ZIP CODE

TRANSIT ROUTING NUMBER (From lower left corner of your check)

ACCOUNT NUMBER



Attach a voided personal check here. This voided check gives the necessary information for your financial institution to deduct your premium from your account.