BlueCross BlueShield of Delaware
A CareFirst Company

MEMBER ENROLLMENT / CHANGE APPLICATION

Enrollment Services, PO Box 8868, Wilmington, DE 19899 • 302.421.3400 • Fax 302.421.8948

Thank you for choosing Blue Cross Blue Shield of Delaware as your health insurance carrier.

Attached is the Member Enrollment / Change Application.

Your employer will fill out the top portion, which includes your account number and sub-account numbers, as well as the requested effective date of your group coverage.

Section One

- Reason For Application/Change. Please indicate the reason for the application/change.
- For life events (marriage, divorce or birth) you have 30 days to apply. However, in order for coverage to begin on the event date, Blue Cross Blue Shield must be notified within 10 days of the event.
- If you are choosing the Blue Care® or Blue Select® product, please be sure to include a PCP for yourself and your dependents. If your employer does not have a provider directory, there is an online provider directory on our website, www.bcbsde.com.

Section Three

Health and Dental Coverage Choices. Please be sure you indicate the plan you are selecting. Please refer to the plan choice that is indicated in the paperwork given to you by your employer.

Section Four

- Dependent Information. When submitting this application to add, cancel or change a dependent, only include the dependents that are having changes.
- If you have more than 3 dependents your employer has extra dependent sheets for you to list the additional dependents.

Section Five

Coordination of Benefits. Complete this section only if you or your dependent(s) is/are covered by another insurance policy that will remain active at the same time of this policy.

Section Eight

Please be sure to sign and date the application.

Please detach this sheet before returning this application to your employer.

bcbsde.com

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THIS LINE IS FOR EMPLOYER USE ONLY	Account Number:	Sub-Account Number:	Effective Date: / /	bcbsde.com

SECTION 1 REASON FOR APPLICATION / CHANGE

☐ New hire

☐ Open Enrollment

Life event: ☐marriage, ☐divorce, ☐birth; date of event : _____/_____/_____

☐ Other (specify): _____

☐ Coverage loss: Reason for loss: _____

Previous carrier and ID number: _____

Date of loss (month, day, year): _____

List who was covered: _____

• To begin COBRA coverage, please submit your COBRA Election Form. • Please forward a HIPAA Certificate with this application or upon receipt, if you want a review of preexisting credit.

SECTION 2 EMPLOYEE INFORMATION

Please Print First Name:	Last Name:	M.I.:	Jr., Sr.:	Social Security or Blue Cross Blue Shield ID Number:

Address—Apartment Number, Street:	City:	State:	Zip Code:

Home Phone: ( )	Employer Name:	Employee Number:	Department Number:

Date of Birth: / /	E-mail Address (optional):	Marital Status: ☐ Single ☐ Married	Gender: ☐ Female ☐ Male	Are you eligible for Medicare? ☐ Yes ☐ No

Employment status: ☐ Full-time ☐ Part-time ☐ Retiree ☐ Other (specify):	Number of hours worked per week:	Date of Hire: / /	Date of Retirement: / /

Name of your selected Primary Care Physician (PCP):	Physician's ID Number:	Is this your current PCP? ☐ Yes ☐ No

SECTION 3 HEALTH AND DENTAL COVERAGE CHOICES

Choose your Health plan from those offered by the employer:	Health coverage is for: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Family	☐ Begin coverage ☐ Terminate coverage

Choose your Dental plan from those offered by the employer:	Dental coverage is for: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Family	☐ Begin coverage ☐ Terminate coverage

If applicable, Dental Health Plus (DHP) Provider ID Number:	Is this your current dentist? ☐ Yes ☐ No

SECTION 4 DEPENDENT INFORMATION

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:

Dependent's relationship to you:	Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No

Dependent's Primary Care Physician:	Physician's ID Number:	Is this the dependent's current PCP? ☐ Yes ☐ No

(continued on the reverse side)

SECTION 4 DEPENDENT INFORMATION continued

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:
Dependent's relationship to you:		Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No
Dependent's Primary Care Physician:		Physician's ID Number:		Is this the dependent's current PCP? ☐ Yes ☐ No

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:
Dependent's relationship to you:		Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No
Dependent's Primary Care Physician:		Physician's ID Number:		Is this the dependent's current PCP? ☐ Yes ☐ No

SECTION 5 COORDINATION OF BENEFITS. If you / your dependent(s) listd on this application have any other health / dental coverage that will remain active, please provide the information requested below.

List those who are covered:	Name of other health / dental insurance carrier:
Effective date of coverage (month, day, year):	Identification Number:

SECTION 6 MEDICARE-ELIGIBLE DEPENDENTS
Complete the section below or send us a copy of your Medicare card.

Your Medicare Claim Number / Health Insurance Code (HIC Number):	Dependent's Medicare Claim Number / Health Insurance Code (HIC Number):
Your hospital coverage (Part A) effective date (month, day, year):	Dependent's hospital coverage (Part A) effective date (month, day, year):
Your medical coverage (Part B) effective date (month, day, year):	Dependent's medical coverage (Part B) effective date (month, day, year):

SECTION 7 TERMS OF AGREEMENT

TERMS OF AGREEMENT. It is understood that: **(1)** Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and Blue Cross Blue Shield of Delaware (BCBSD). **(2)** I certify that representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete. **(3)** I authorize my employer, as my agent, if applicable to collect premiums by payroll deduction, for remittance to BCBSD, with the understanding that payment will not be complete until actually received by BCBSD. **(4)** Any physician, hospital or other health care provider shall release to BCBSD or its designee any of my and my covered dependents' protected health information for the purpose of payment, health care plan operations, or as otherwise required by law.

SECTION 8 TODAY'S DATE (month, day, year)	YOUR SIGNATURE