



GROUP PRODUCT ENROLLMENT AND CHANGE FORM

Complete this application in blue or black ink.
DO NOT USE A PENCIL OR HIGHLIGHTER.

2007 HIPAA COMPLIANT

An Independent Licensee of the Blue Cross Blue Shield Association

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental application from your Group Administrator.

Social Security Number	Group Number	Group Name	Effective Date	Dept. Code

Level of Benefits Applied for: Single Adult & Child Two Adults Adult & Child(REN) Family

REASON FOR COMPLETION: New Enrollee Changes (see below) Cancel (see below) Re-enrollment Waiver

COMPLETION: COBRA Start Date _____ COBRA End Date _____ (see below)

DEPENDENT CHANGES: Add Dependents due to: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Date of Above Event _____ Drop Dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	OTHER CHANGES: <input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage <input type="checkbox"/> Other _____ Date of Above Event _____	CANCEL/COBRA REASON: <input type="checkbox"/> Deceased <input type="checkbox"/> Left Employment <input type="checkbox"/> Involuntary Lay-Off <input type="checkbox"/> Other Coverage <input type="checkbox"/> Other _____ Date of Above Event _____
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Applicant's Last Name (Please Use the Boxes) _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____ County _____

Birthdate Mo Da Yr _____ _____ _____	Phone Number () _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date Married Mo Da Yr _____ _____ _____
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Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra	Date of Full Time Hire Mo Da Yr _____ _____ _____	Hours Worked Per Week	Job Title
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COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	Birthdate Mo/Da/Yr	Gender M/F	Last Name	First Name	Social Security #	Dependent Status if Over Age 19
SPOUSE						
<input type="checkbox"/> Child <input type="checkbox"/> Other						<input type="checkbox"/> Full-time Student
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Disabled
<input type="checkbox"/> Child <input type="checkbox"/> Other						<input type="checkbox"/> Full-time Student
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Disabled
<input type="checkbox"/> Child <input type="checkbox"/> Other						<input type="checkbox"/> Full-time Student
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Disabled

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other, and may be requested in other instances.

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S).

I HEREBY DECLINE COVERAGE

For MYSELF

For MYSELF and ALL FAMILY MEMBERS

For FAMILY MEMBERS ONLY

For the FOLLOWING PERSON(S): _____

REASON FOR DECLINING COVERAGE:

HAVE NOT MET EMPLOYER'S ELIGIBILITY

INSURED UNDER SPOUSE'S CONTRACT with the following Insurance Carrier _____

OTHER _____

I Hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment occurs before coverage will be offered. Any pre-existing conditions specified in the contract will apply.

Signature _____ Date _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

STOP HERE IF DECLINING COVERAGE FOR YOURSELF

ABOUT YOUR UNIVERSAL MEDICAL APPRAISAL FORM

If applicable, did you complete the Universal Medical Appraisal Form for all enrolled dependents? YES NO N/A

If you answered NO, please provide a completed Universal Medical Appraisal Form.

If you answered YES, have there been any changes to the medical histories previously provided? YES NO

If YES, please provide an updated Universal Medical Appraisal Form for all enrolled dependents.

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Have you or any of your dependents had previous health coverage? YES NO. If "YES", complete the following boxes, including the effective and cancel dates.

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date	Cancel Date	Coverage Type(s)
					<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision

REASON FOR CANCELING

MOST RECENT COVERAGE:

The above section can be used by MSBCBS in lieu of Certificate of Coverage and will be used, in part, as the basis in determining the pre-existing condition waiting period, if applicable. MSBCBS may require other documentation such as Certificate of Coverage, EOB's, etc. in determining pre-existing condition waiting periods. YOU have a right to demonstrate creditable coverage and to request a Certificate of Coverage from a prior carrier. We will provide assistance if you cannot obtain a Certificate of Coverage from your prior carrier.

Medicare Information - Check the appropriate boxes and fill in all information for you and any dependents who are covered by Medicare.

You Medicare # _____ Eff. Date - Part A: / / Part B: / / Check this box for each individual who is receiving treatment for end-stage renal disease.

Spouse Medicare # _____ Eff. Date - Part A: / / Part B: / /

Dependent Medicare # _____ Eff. Date - Part A: / / Part B: / /

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

THIS SECTION MUST BE COMPLETED ONLY WHEN ENROLLING IN A SUPER BLUE SELECT POS PRODUCT

Family Member Name First, Middle, Last (include Yourself)	Primary Care Physician (PCP) (First and Last Name)	PCP ID# (as listed in Directory)	Are you an Existing Patient of this PCP?	
			Y	N
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Do any of the dependents listed above live in a different city? Y or N. If YES list below the dependent(s) and the city and state in which they live.

1. Dependent _____ City & State _____ 2. Dependent _____ City & State _____

IMPORTANT: APPLICATION FOR COVERAGE

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or rescission of coverage and may subject me to legal action by Mountain State Blue Cross & Blue Shield. I also understand under WV Code §33-41-3, "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." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Mountain State Blue Cross & Blue Shield unless and until this Application for coverage is approved and I have been provided with an Effective Date and Group Number, and only as long as the Group continues to qualify under the terms of the Group contract with MSBCBS, including timely payment of premiums.

If applicable, I understand that unless I or my dependents have twelve (12) months of Creditable Coverage, as defined by the Health Insurance Portability and Accountability Act of 1996, this coverage will not pay for any loss incurred during the first twelve (12) months after the earlier of the effective date of this coverage or the 1st day of a waiting period, for any condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period prior to the earlier of the effective date of this coverage or the 1st day of a waiting period. Please see your health care certificate for a more detailed explanation. This pre-existing condition exclusion period will be reduced by any days of Creditable Coverage that occurred before a "Significant Break in Coverage" defined as a period of sixty-three (63) consecutive days during all of which the individual does not have any Creditable Coverage.

Applicant's Signature _____ **Date** _____

Send to:
MOUNTAIN STATE BLUE CROSS BLUE SHIELD
 P.O. Box 1948
 Parkersburg, WV 26102