



GROUP PRODUCT ENROLLMENT AND CHANGE FORM

Complete this application in blue or black INK.

DO NOT USE A PENCIL OR A HIGHLIGHTER.

2008 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

Coverage Applied for: New Blue SuperBlue Plus SuperBlue Select HDHP Limited Benefit

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

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"/> Married <input type="checkbox"/> Widowed <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"/> FT Student <input type="checkbox"/> Disabled
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Eligible Dependent
<input type="checkbox"/> Child <input type="checkbox"/> Other						<input type="checkbox"/> FT Student <input type="checkbox"/> Disabled
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Eligible Dependent
<input type="checkbox"/> Child <input type="checkbox"/> Other						<input type="checkbox"/> FT Student <input type="checkbox"/> Disabled
<input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted						<input type="checkbox"/> Eligible Dependent

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other.

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 <input type="checkbox"/> For MYSELF <input type="checkbox"/> For MYSELF and ALL FAMILY MEMBERS <input type="checkbox"/> For FAMILY MEMBERS ONLY <input type="checkbox"/> For the FOLLOWING PERSON(S) _____	REASON FOR DECLINING COVERAGE: <input type="checkbox"/> HAVE NOT MET EMPLOYER'S ELIGIBILITY <input type="checkbox"/> INSURED UNDER SPOUSE'S CONTRACT with the following Insurance Carrier _____ <input type="checkbox"/> OTHER _____
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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 in the future be able 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 OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Please list any previous coverage for you or any of your dependents for the past 18 months. Indicate effective and cancel dates. If the coverage listed will not be cancelled, but will coordinate coverage as a primary or secondary payor, please indicate by checking the appropriate box.

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"/> Previous <input type="checkbox"/> Primary/Secondary
					<input type="checkbox"/> Medical <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Previous <input type="checkbox"/> Primary/Secondary

REASON FOR CANCELING

MOST RECENT COVERAGE:

The above section can be used by MSBCBS in lieu of Certificate of Creditable 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 Creditable 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 Creditable Coverage from a prior carrier. We will provide assistance if you cannot obtain a Certificate of Creditable 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.

<input type="checkbox"/> You	Medicare # _____	Eff. Date - Part A: / / Part B: / /	<input type="checkbox"/>	Check this box for each individual who is receiving treatment for end-stage renal disease.
<input type="checkbox"/> Spouse	Medicare # _____	Eff. Date - Part A: / / Part B: / /	<input type="checkbox"/>	
<input type="checkbox"/> Dependent	Medicare # _____	Eff. Date - Part A: / / Part B: / /	<input type="checkbox"/>	

MEDICAL HISTORY INFORMATION

YOUR HEIGHT (ft./in.) _____ YOUR WEIGHT (lbs.) _____ SPOUSE'S HEIGHT(ft.in.) _____ SPOUSE'S WEIGHT (lbs.) _____

Have you or any of your dependents EVER had any of the conditions listed below? If so, please indicate by marking "X" in each appropriate box. List in the Explanation Section the patient's name, diagnosis, treatment(s) and treatment date(s), surgeries and surgery date(s), and the prognosis for each condition marked.

1. CANCERS

Site of cancer _____ List all other requested information in the Explanation Section

2. HEART/LUNG

- Anemia
- Aneurysm
- Arteriosclerosis
- Congenital Heart Disease
- Congestive Heart Failure
- Heart Attack
- Hemophilia
- Hypertension
- Ischemic Heart Disease
- Rheumatic Heart Disease
- Stroke
- Valvular Disease
- Apnea
- Asthma
- Cystic Fibrosis
- Emphysema
- Tuberculosis

4. IMMUNE

- AIDS
- ARC - AIDS Related Complex
- Any Immune Suppressed Illness
- HIV-list status in Explanation Section
- Kaposi's Sarcoma
- Systemic Lupus

5. RENAL

- Blood in Urine
 - Dialysis
 - Polycystic Kidney Disease
 - Renal Failure
- Acute _____ Chronic _____

6. DIGESTIVE/INTESTINAL

- Cirrhosis of Liver
- Colostomy
- Crohn's Disease
- Diabetes: Juvenile _____ Adult _____
- Diet Controlled _____ Oral Medications _____
- Insulin _____ Units/Day _____
- Hepatitis Type: A _____ B _____ C _____
- Pancreatitis
- Ulcerative Colitis

7. NEUROLOGICAL/PSYCHOLOGICAL

- Alzheimer's
- Amyolateral Sclerosis ---- Lou Gehrig's Disease
- Attempted Suicide
- Cerebral Palsy
- Depression
- Drug/Alcohol Abuse
- Multiple Sclerosis
- Paralysis
- Parkinson's
- Spina Bifida: Cystica _____ Occulta _____

8. MUSCULAR/SKELETAL

- Amputation
- Arthritis: Rheumatoid _____ Osteo _____
- Degenerative Disc or Joint Disease
- Herniated Disc
- Joint Replacement
- Marfans Syndrome
- Muscular Dystrophy

9. REPRODUCTIVE

- Infertility: In Vitro _____ GIFT _____
- Pregnant, Due Date: _____/_____/_____
- Sexually Transmitted Disease(s)
- Other Reproductive

3. HEART/LUNG TREATMENTS

- Angioplasty
- Bypass
- Cardiac Catheterization
- Pace Maker Implantation
- Heart Valve Replacement

ANY QUESTIONS BELOW ANSWERED WITH A "YES" MUST BE EXPLAINED IN THE EXPLANATION SECTION

- | | | |
|------------------------------|--------------------------|---|
| Y | N | |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents ever had or been advised to have an organ or bone marrow transplant? |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Do you or any of your dependents have any other medical conditions not listed above that have been diagnosed or treated by a health care provider the past FIVE years? |
| 12. <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents been hospitalized or had surgery within the past FIVE years? |
| 13. <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents been advised to have surgery which has not been performed yet? |
| 14. <input type="checkbox"/> | <input type="checkbox"/> | Are you or any of your dependents currently taking prescription medications? If yes, please list patient's name, name of medication, dosage, and the reason taking the medication in the Explanation Section. |
| 15. <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents been treated by a health care provider six months prior to your enrollment date? If yes, please explain. |
| 16. <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents ever been covered by Worker's Compensation, Disability, or Subrogation for any of the conditions listed in the Medical History Section above? |

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
U/A RQ Date	Membership Received Date (2)	On INSINQ
U/A Rcv RQ Date		INQUIRY CLOSED
Completed or Closed	Verified	ID Mailed

Date Approved _____

Approved By _____

Date Denied _____

Coverage Effective Date _____

This is a Waiver _____

Date Rec'd by Membership _____

Date on System _____

INSINQ Inquiry Number _____

Send to:

MOUNTAIN STATE BLUE CROSS BLUE SHIELD

P.O. Box 1948

Parkersburg, WV 26102