South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

BLUE MEASURE MEMBERSHIP APPLICATION

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI):_____ **2.** Birthdate:_____/_____/_____ **3.** Male ☐ Female ☐

4. Address: (Street)_____ (City)_____ (State)_____ (ZIP)_____

5. Employee Social Security Number: _____ **6.** Phone: (_____) _____

7. Email (Required):_____ **8.** Name of Employer:_____

9. Group Number: _____ **10.** Effective Date of Action Requested: _____/ _____/ _____

REASON FOR APPLICATION

11. ☐ New Member – Full-time employee working an average of 30 hours per week? ☐ Yes ☐ No Full-time Date of Hire: _____/_____/_____

☐ Coverage Change – Reason for Change:_____ Date of Occurrence:_____/_____/_____

☐ Cancellation – Date Left Employment: _____/_____/_____

☐ Reinstatement – Reason: ☐ Return from Layoff ☐ Return from Leave

☐ COBRA: Start Date: _____/_____/_____

☐ Sponsored Membership – Sponsored Member's Social Security Number: _____

COVERAGE INFORMATION

Plan Name: Choose an item

12. MEDICAL ELECTION

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

☐ No Medical Coverage Due To: Choose an item (if applicable) Explain Other (05):_____

13. DENTAL ELECTION

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ No Dental Coverage

ENROLLMENT INFORMATION (List all individuals to be covered.)

14.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Other Insurance Yes	Other Insurance No
Spouse						☐	☐
Child						☐	☐
Child						☐	☐
Child						☐	☐
Child						☐	☐

OTHER COVERAGE INFORMATION

15. If you or any of your family members have other health (including Medicare), dental or drug coverage other than with this employer, what is the name of the insurance company and the policyholder's ID number?:_____

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*

I authorize release to Blue Cross and Blue Shield of South Carolina (BlueCross) or its representatives all past and future medical records for myself and eligible dependents and other information deemed necessary by BlueCross to review, process or investigate claims. This authorization includes Medicare Parts A and B claims. I understand the benefits for which I (we) will be eligible are those described in the Employer Plan of Benefits and administered by BlueCross BlueShield of South Carolina. I also understand that my coverage may be voided or terminated, or claims denied if fraud or intentional misrepresentations of materials facts have been made on this application subject to the Time Limit on Certain Defenses provisions. The statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for up to 12 months.

Blue Cross and Blue Shield of South Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature:_____ **Date**:_____