ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of New Mexico

Group No. | Section No. | Dept No. | Social Security No.

Group No. | Section No. | Dept No. | Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8, AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Change(s)**

Are you applying as a result of a Special Enrollment Event? ☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth, Adoption, Suit for Adoption

☐ Court Order (see instructions)

☐ Loss of Other Coverage (provide Certificate of Creditable Coverage)

☐ Other (Explain) ______________________

NOTE: Declination of Coverage (Complete Sections 2, 8 & 9)

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

List names of those cancelling in Section 4 below

Event: ☐ Divorce ☐ Death

☐ Terminated Employment

☐ Other

Indicate Event Date: ____ / ____ / ____

Cancel Coverage: ☐ Health ☐ Dental

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No. – –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	On average, how many hours do you work per week? (Required)

Eligibility Status: ☐ Active Employee ☐ COBRA Continuation ☐ Retired Employee - Date of Retirement: ______________ ☐ State Six-Month Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 employees)

Health Coverage (select one)	Who is covered? (select one)	BlueCare Dental Coverage	Who is covered? (select one)
☐ Blue PPO	☐ Employee Only	☐ Yes	☐ Employee Only
☐ Blue EPO	☐ Employee /Spouse	☐ No	☐ Employee /Spouse
☐ BlueAdvantage HMO℠*	☐ Employee /Child(ren)		☐ Employee /Child(ren)
☐ Blue HMO	☐ Family		☐ Family
7-character Plan # (required) ______	☐ I am not applying for Health coverage		☐ I am not applying for Dental coverage

*Plan is available for groups located in and members residing in the following counties: Bernalillo, Sandoval, Torrance, Valencia

Large Group Plans (51 or more employees)

Health Coverage (select one)		Who is covered? (select one)	Dental Coverage	Who is covered? (select one)
☐ BlueEdge℠ HCA	☐ Blue PPO Evolution℠	☐ Employee Only	☐ Yes	☐ Employee Only
☐ BlueEdge℠ HSA	☐ Blue PPO Options℠	☐ Employee /Spouse	☐ No	☐ Employee /Spouse
☐ BlueEdge℠ HSA 100	☐ HMO Blue®	☐ Employee /Child	Plan # (required)	☐ Employee /Child
☐ BlueNet® EPO	☐ HMO Blue® Alternatives	☐ Employee /Child(ren)		☐ Employee /Child(ren)
☐ BlueNet® "H" EPO		☐ Family	______	☐ Family
		☐ I am not applying for Health coverage		☐ I am not applying for Dental coverage

Additional Coverage

☐ COBRA ☐ BlueSecure ☐ Six-Month Continuation ☐ Group Secondary to Medicare

Applicant's Primary Language: ______________________

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No. – –	Birth Date (MM/DD/YYYY)	Address (if different) - No. And Street Address	City	State	Zip

Dependent's Name: ______ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ______	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Dependent's Name: ______ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ______	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Dependent's Name: ______ ☐ Son ☐ Daughter ☐ Other Eligible Dependent ______	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child or adopted child? ☐ Y ☐ N If no, attach copy of court order or decree.	If not your natural child, stepchild, eligible foster child or adopted child, are you (or your spouse) financially responsible for this dependent? ☐ Y ☐ N	

Last Name: Social Security No: — — Group #

SECTION 5 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 6 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child ☐ Employee/Children ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 7 — MEDICARE COVERAGE INFORMATION

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 8 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for Declining **Health**: ☐ Other Group Health Coverage; Carrier: _____ ☐ Indian Health Services ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Indian Health Services ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for Declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Indian Health Services ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

SECTION 9 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that this coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

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 CIVIL FINES AND CRIMINAL PENALTIES.

Applicant's Signature _____ Date _____