

GROUP EMPLOYEE APPLICATION

Group Name: City of Pine Bluff

Group #: _____

New Enrollee (___ / ___ / ___)

Cancel Coverage (___ / ___ / ___)

Add/Remove Family Member

Change of Information

Section 1. EMPLOYEE INFORMATION

Last Name	First Name	MI	Date of Birth / /	Gender	SSN - -
Address		City		State	Zip Code
Home Phone #	Cell Phone #	Department			Full-time Hire Date / /
Email Address					

Section 2. PLAN SELECTION (check one)

BASE PLAN (\$2000 Deductible)

OR

BUY-UP PLAN (\$1000 Deductible)

Employee Only

Employee Only

Family Coverage

Family Coverage

Section 3. DEPENDENT INFORMATION

Full Name (First, MI, Last)	Relationship	Home Zip Code	Date of Birth / /	Gender	SSN - -
			/ /		- -
			/ /		- -
			/ /		- -
			/ /		- -
			/ /		- -

Section 4. OTHER INSURANCE (if applicable)

Are any of the members listed above covered by another insurance company? Yes No

On the day coverage begins, will any family members listed above be covered by Medicare?
If yes, please answer all questions below. Yes No

Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply): Medicare Part A—Eff. Date: ___ / ___ / ___ Medicare Part B—Eff. Date: ___ / ___ / ___

Section 5. SIGNATURES (please read before signing)

I understand that the benefits for which I (we) will be eligible are those described in the Arkansas BlueCross & BlueShield policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date. In signing this application, I represent that the statements and answers given in this application are true, complete & correctly recorded. I understand that Arkansas BlueCross & BlueShield may, within 3 years of the date of this application, void or terminate this coverage or deny any claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, Arkansas BlueCross & BlueShield may take legal action at any time.

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.

Employee Signature: _____ **Date:** _____

Group Administrator: _____ **Date:** _____