BlueCross BlueShield of Oklahoma

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Blue Cross and Blue Shield of Oklahoma

BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.
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FOR OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE

SMALL BUSINESS
APPLICATION *for* MEMBERSHIP

RETURN THIS FORM TO:
Blue Cross and Blue Shield of Oklahoma • Enrollment Services • P.O. Box 3283 • Tulsa, Oklahoma 74102-3283

TELL US WHO YOU WANT TO ENROLL FOR HEALTH BENEFITS COVERAGE *(CHECK ONE BOX)*

☐ EMPLOYEE ONLY	☐ EMPLOYEE AND SPOUSE	EMPLOYEE AND UNMARRIED CHILDREN	☐ EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN
PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 7 AND 10 THROUGH 13	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 8 AND 10 THROUGH 13	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 7 AND 9 THROUGH 13	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 13

TELL US WHAT TYPE COVERAGE YOU CHOOSE *(CHECK ONE BOX)*

1

BLUELINCS HMO	BLUEPREFERRED	BLUECHOICE	BLUETRADITIONAL	BLUEOPTIONS	HSA BLUE
☐	☐	☐	☐	☐	☐

TELL US ABOUT YOURSELF *(PLEASE PRINT IN INK OR TYPE)*

2 NAME OF APPLICANT (EMPLOYEE) (LAST, FIRST, MIDDLE) | RESIDENCE TELEPHONE A/C

3 (STREET OR BOX NO.) (CITY) (STATE) (9-DIGIT ZIP CODE) ☐☐☐☐☐ – ☐☐☐☐

4 SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YR. | SEX M ☐ F ☐ | MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED | BUSINESS PHONE A/C

5 I AM EMPLOYED BY (COMPANY, CITY, STATE) | HOW MANY HOURS PER WEEK DO YOU WORK? | DATE EMPLOYED FULL-TIME MO. DAY YR. | EMPLOYER GROUP NO. (TO BE COMPLETED BY EMPLOYER FOR SUBSEQUENT HIRES)

6 DOES ANYONE LISTED ON THIS APPLICATION HAVE HEALTH INSURANCE, MEDICARE OR MEDICAID, OR HAS ANYONE LOST COVERAGE DURING THE LAST 2 MONTHS? ☐ YES ☐ NO | IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME

INSURED'S NAME | MEMBER ID/SUBSCRIBER NO./ CASE NO. | GROUP NO./POLICY NO. | PERSONS COVERED ☐ APPLICANT ☐ SPOUSE ☐ DEPENDENTS LISTED ON APPLICATION ☐ OTHER____

HAS COVERAGE TERMINATED? ☐ YES, ON ___/___/___ ☐ NO

IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED?
☐ YES, CURRENT COVERAGE WILL BE TERMINATED
☐ NO, I WILL KEEP BOTH COVERAGES

***NOTE:** IF MORE THAN (1) ONE INSURANCE POLICY, PLEASE PROVIDE THE INFORMATION ON ITEM 6 FOR ADDITIONAL INSURANCE CARRIERS ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THIS APPLICATION.*

7 *IF YOU HAVE SELECTED BLUELINCS HMO OR BLUEPREFERRED W/PCP, THE FOLLOWING INFORMATION IS REQUIRED:*
EMPLOYEE'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) | IS THIS YOUR CURRENT PHYSICIAN ☐ YES ☐ NO | PCP NUMBER FROM PROVIDER DIRECTORY **PCP-** ☐☐☐☐☐☐

FOR OFFICE USE ONLY

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVA CODE	W/C EFF. DATE	W/C EXP DATE	PROD. CODE	DIVISION CODE	CROSS REFERENCE AGREEMENT NO.

COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	SUB CHAR.	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP. DENT. CHAR.

LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	SPECIAL NOTES	CODED BY

PLEASE TURN THE PAGE

TELL US ABOUT OTHER FAMILY MEMBERS APPLYING FOR COVERAGE: IF APPLYING FOR BLUELINCS HMO OR BLUE PREFERRED WITH PCP, THE PRIMARY CARE PHYSICIAN'S NAME MUST BE PROVIDED FOR YOUR SPOUSE/DEPENDENT(S).

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NAME OF SPOUSE (FIRST, MIDDLE, LAST) | DATE OF BIRTH MO. DAY YR. | SOCIAL SECURITY NUMBER | MARRIAGE DATE MO. DAY YR.

SPOUSE'S EMPLOYER (NAME OF COMPANY, CITY, STATE) | DATE EMPLOYED FULL-TIME | HOW MANY HOURS WORKED PER WEEK BY SPOUSE? | BUSINESS PHONE A/C

SPOUSE'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) | IS THIS YOUR SPOUSE'S CURRENT PHYSICIAN ☐ YES ☐ NO | PCP NUMBER FROM PROVIDER DIRECTORY PCP-

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DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO EMPLOYEE ☐ SON/STEP-SON ☐ DAUGHTER/STEP-DAUGHTER ☐ OTHER (DESCRIBE): ______ | DATE OF BIRTH MO. DAY YR.

SOCIAL SECURITY NO. | DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) | IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN ☐ YES ☐ NO | PCP NUMBER FROM PROVIDER DIRECTORY PCP-

IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. ☐YES ☐NO
IS THIS DEPENDENT MARRIED? ☐YES ☐NO
ARE YOU (OR YOUR SPOUSE) LEGALLY *AND* FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐YES ☐NO
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: ☐YES ☐NO

NAME OF INSTITUTION: ______ CITY/STATE ______ HOURS ENROLLED: ______

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO EMPLOYEE ☐ SON/STEP-SON ☐ DAUGHTER/STEP-DAUGHTER ☐ OTHER (DESCRIBE): ______ | DATE OF BIRTH MO. DAY YR.

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IS THIS DEPENDENT MARRIED? ☐YES ☐NO
ARE YOU (OR YOUR SPOUSE) LEGALLY *AND* FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐YES ☐NO
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: ☐YES ☐NO

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DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO EMPLOYEE ☐ SON/STEP-SON ☐ DAUGHTER/STEP-DAUGHTER ☐ OTHER (DESCRIBE): ______ | DATE OF BIRTH MO. DAY YR.

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IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: ☐YES ☐NO

NAME OF INSTITUTION: ______ CITY/STATE ______ HOURS ENROLLED: ______

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO EMPLOYEE ☐ SON/STEP-SON ☐ DAUGHTER/STEP-DAUGHTER ☐ OTHER (DESCRIBE): ______ | DATE OF BIRTH MO. DAY YR.

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NAME OF INSTITUTION: ______ CITY/STATE ______ HOURS ENROLLED: ______

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO EMPLOYEE ☐ SON/STEP-SON ☐ DAUGHTER/STEP-DAUGHTER ☐ OTHER (DESCRIBE): ______ | DATE OF BIRTH MO. DAY YR.

SOCIAL SECURITY NO. | DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) | IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN ☐ YES ☐ NO | PCP NUMBER FROM PROVIDER DIRECTORY PCP-

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IS THIS DEPENDENT MARRIED? ☐YES ☐NO
ARE YOU (OR YOUR SPOUSE) LEGALLY *AND* FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐YES ☐NO
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: ☐YES ☐NO

NAME OF INSTITUTION: ______ CITY/STATE ______ HOURS ENROLLED: ______

10 STATEMENT OF HEALTH

- ANSWER THESE HEALTH QUESTIONS (BELOW) FOR EACH PERSON APPLYING FOR HEALTH COVERAGE.
- ALL QUESTIONS MUST BE ANSWERED YES OR NO (ATTACH ADDITIONAL SHEET(S) IF NECESSARY.)

DO YOU (THE APPLICANT) OR ANY FAMILY MEMBER APPLYING FOR COVERAGE ON THIS APPLICATION ...

		YES	NO
1.	HAVE OR HAVE EVER HAD AIDS, AIDS RELATED COMPLEX OR IMMUNE SYSTEM DISORDER (HIV)?	☐	☐
2.	HAVE OR EVER HAD ANY DISEASE OR DISORDER OF THE HEART OR CIRCULATORY SYSTEM, HIGH BLOOD PRESSURE, HEART ATTACK, PHLEBITIS?	☐	☐
3.	HAVE OR EVER HAD ANY DIABETES, THYROID OR OTHER GLANDULAR DISORDER?	☐	☐
4.	HAVE OR EVER HAD ANY TYPE OF CANCER, TUMOR, CYST, GROWTH OR SKIN DISORDER?	☐	☐
5.	HAVE OR EVER HAD ANY DISEASE OR DISORDER OF THE STOMACH, OR INTESTINES, GALLBLADDER, LIVER, PANCREAS, OR RECTUM?	☐	☐
6.	HAVE OR EVER HAD ANY DISEASE OF THE LUNGS OR RESPIRATORY SYSTEM, ASTHMA, TUBERCULOSIS, EMPHYSEMA?	☐	☐
7.	HAVE OR EVER HAD ANY DISEASE OR DISORDERS OF THE BACK, SPINE, BONES, JOINTS, ARTHRITIS?	☐	☐
8.	HAVE OR EVER HAD ANY DISEASE OR DISORDER OF THE BRAIN OR NERVOUS SYSTEM, EPILEPSY, CONVULSIONS, MIGRAINE HEADACHES, STROKES OR PARALYSIS?	☐	☐
9.	HAVE OR EVER HAD ANY DISEASE OR DISORDER OF THE BLOOD OR LYMPH GLANDS?	☐	☐
10.	HAVE OR EVER HAD ANY DISORDER OF THE MALE OR FEMALE GENITAL AND/OR URINARY SYSTEMS?	☐	☐
11.	HAVE OR EVER HAD RECEIVED OR EVER HAVE HAD TREATMENT FOR ALCOHOL OR DRUG ABUSE?	☐	☐
12.	HAVE OR EVER HAD ANY ABNORMALITY, DEFORMITY, OR DISORDER NOT ALREADY SPECIFIED, OR ANY CONDITION THAT MAY REQUIRE TREATMENT?	☐	☐
13.	CONSULT A PHYSICIAN OR HEALTH PRACTITIONER CURRENTLY OR HAVE CONSULTED WITH ONE, FOR ANY REASON, IN THE PAST THREE YEARS?	☐	☐
14.	HAVE A HISTORY OF HOSPITALIZATION IN THE PAST THREE YEARS OR ARE NOW HOSPITALIZED?	☐	☐

	EXACT HEIGHT	EXACT WEIGHT
APPLICANT	FEET ______ INCHES ______	______ LBS.
SPOUSE	FEET ______ INCHES ______	______ LBS.

COMPLETE THIS SECTION FOR EACH QUESTION ANSWERED "YES"

QUESTION NUMBERS	PERSON AFFECTED	TYPE OF AILMENT, SYMPTOM, OR DIAGNOSIS OF CONDITION	DEGREE OF RECOVERY	ONSET DATE	DATE OF LAST TREATMENT OR SURGERY	PRESCRIPTION DRUGS (LIST DATES TAKEN)	NAME(S) AND ADDRESSES OF PHYSICIAN, PRACTITIONER, HOSPITAL OR INSTITUTION
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		

PLEASE CONTINUE TO PAGE 4

11 NOTICE: You are considered a Timely Enrollee if your application is received by the Plan within 31 days of your eligibility period (when any group initially enrolls or as a new hire upon completion of a waiting period, if any, as specified in the group contract). If you are declining enrollment for your spouse or your dependents because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependents in this plan provided you request Special enrollment within 31 days after the other coverage ends. Qualifying events for this Special enrollment include termination of employment, reduction of work hours, legal separation, divorce, death, employer contributions toward the other coverage have terminated, or COBRA or state continuation of coverage has been exhausted. If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself, your spouse, and your dependents, provided you request Special enrollment within 31 days of the event and provide documentation showing the date of the event. If you do not enroll upon the initial offering of this coverage (Timely Enrollee) or do not enroll as a Special Enrollee, you, your spouse and/or your dependent may apply during the Open Enrollment period (31 days prior to your group's renewal date) as a Late Enrollee.

- There is a Preexisting Condition limitation on the coverage available from the Plan (except for BlueLincs HMO coverage). A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. A Preexisting Condition will not apply to pregnancy or to a newborn or adopted child under age 18, provided the child becomes covered under the Contract/Agreement within 31 days of birth or adoption. The length of the Preexisting Condition limitation period is 12 months after the enrollment date for Timely and Special Enrollees, and 18 months for Late Enrollees. The Preexisting Condition limitation waiting period may be reduced by the number of days you (and/or your spouse, and/or dependents) were covered under a prior health insurance plan(s) should there be no more than a 63-day break in coverage, excluding your waiting period, if any. To do this you may request a Certificate of Coverage form from the prior health plan(s) or issuer and send it to our Enrollment Services department. After the amount of prior creditable coverage has been determined, we will notify you of Preexisting Condition credit based on your prior coverage. Please attach your Certificate of Coverage, if you currently have one.

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- AGREEMENTS AND SIGNATURES (PLEASE READ, SIGN AND DATE)

I, on behalf of myself and any persons whose names appear on this application, hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma or BlueLincs HMO (herein called the "Plan") as stated in this application. I agree that if my application is accepted, coverage will be effective on the effective date assigned by the Plan. I further agree that any changes in my coverage will not become effective until approved by the Plan. I understand that this is an application only, and I should not cancel any existing coverage until I an notified of acceptance, in writing, by the Plan. If I have selected Blue Cross and Blue Shield of Oklahoma coverage, I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma and to vote in my name upon any matters arising at said meetings. However, I retain the right to vote at any and all meetings of the members.

- I have read all the statements and notices on this application and represent that those items are true and complete to the best of my knowledge and belief. I know that any material misstatements or omissions of information that are made on this application may be the basis for later withdrawal of insurance coverage or denial of a loss incurred during my or my dependent's coverage. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the Plan.
- That if my application is being handled through a broker or agent, I authorize that broker or agent to receive and review my application, which may contain medical information about me or other family members listed on this application.

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SIGNATURE OF APPLICANT (EMPLOYEE) I AGREE TO ALL THE TERMS OF THIS APPLICATION	DATE SIGNED MO.	DAY	YR.	SIGNATURE OF SPOUSE I AGREE TO ALL THE TERMS OF THIS APPLICATION	DATE SIGNED MO.	DAY	YR.
X				X			