

# SMALL BUSINESS APPLICATION/ REQUEST FOR CHANGE IN MEMBERSHIP



**BlueCross BlueShield  
of Oklahoma**



**BlueLines**  
Blue Cross and Blue Shield of Oklahoma

**SOCIAL SECURITY NUMBER AND GROUP #\* ARE REQUIRED TO PROCESS APPLICATION**

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**SOCIAL SECURITY NUMBER**

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**GROUP # (\*IF ASSIGNED)**

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**SECTION #**

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**DEPT #**

CATEGORY \_\_\_\_\_

## SECTION 1 — ENROLLMENT EVENTS PLEASE CHECK ALL THAT APPLY

NEW ENROLLEE     ADD DEPENDENT     CHANGE PRIMARY CARE PHYSICIAN (PCP)  
 OTHER CHANGE(S): INDICATE CHANGE(S) IN APPROPRIATE SECTION BELOW     CHANGE ADDRESS/NAME

ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT?     NO     YES, EVENT DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EVENT:     MARRIAGE     BIRTH  
 ADOPTION OR PLACEMENT FOR ADOPTION (SEE INSTRUCTIONS)  
 COURT ORDER (SEE INSTRUCTIONS)  
 LOSS OF COVERAGE (PROVIDE CERTIFICATE OF CREDITABLE COVERAGE)  
 INSURE OKLAHOMA (O-EPIC)  
 OTHER (SEE INSTRUCTIONS) EXPLAIN: \_\_\_\_\_

CANCEL ENROLLEE     CANCEL DEPENDENT

LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW

EVENT:     DIVORCE     DEATH  
 TERMINATED EMPLOYMENT  
 OTHER

INDICATE EVENT DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DECLINATION OF COVERAGE (REFER TO SECTION 9)

## SECTION 2 — PLEASE TELL US ABOUT YOURSELF

LAST NAME	FIRST	MIDDLE	BIRTH DATE (MM/DD/YYYY) / /	HOME PHONE NO.
HOME ADDRESS — NO. AND STREET ADDRESS	CITY	STATE	ZIP	WORK PHONE NO.
NAME OF EMPLOYER		EMPLOYMENT DATE (MM/DD/YYYY) / /	DO YOU WORK 24 OR MORE HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOCIAL SECURITY NO.       -	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	APPLICANT'S PCP NAME (HMO ONLY)	PCP NO.	NEW PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO

## SECTION 3 — SELECT YOUR COVERAGE

ENROLLEES (SELECT ONE) <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/UNMARRIED CHILD(REN) <input type="checkbox"/> EMPLOYEE/SPOUSE/UNMARRIED CHILD(REN)	COVERAGE (SELECT ONE) <input type="checkbox"/> BlueLines HMO <input type="checkbox"/> BluePreferred® <input type="checkbox"/> BlueChoice® <input type="checkbox"/> BlueTraditional® <input type="checkbox"/> BlueOptions® <input type="checkbox"/> HSA BLUE	DEDUCTIBLE OPTION \$ _____ (IF MORE THAN ONE IS AVAILABLE)
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## SECTION 4 — TELL US ABOUT YOUR DEPENDENTS SELECT A PRIMARY CARE PHYSICIAN (HMO ONLY / BLUE SHADED SECTIONS)

DEPENDENT'S NAME <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	DEPENDENT'S PCP NAME (HMO ONLY)	PCP NO. (HMO ONLY)	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT'S SOCIAL SECURITY NO.       -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY    STATE    ZIP
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	DEPENDENT'S PCP NAME (HMO ONLY)	PCP NO. (HMO ONLY)	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT'S SOCIAL SECURITY NO.       -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY    STATE    ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	DEPENDENT'S PCP NAME (HMO ONLY)	PCP NO. (HMO ONLY)	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT'S SOCIAL SECURITY NO.       -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY    STATE    ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	DEPENDENT'S PCP NAME (HMO ONLY)	PCP NO. (HMO ONLY)	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT'S SOCIAL SECURITY NO.       -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY    STATE    ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**SECTION 5 – STUDENTS OVER AGE 19**

Please complete this section for all dependents listed above and applying for coverage that are over age 19 and under age 23 (or other age limit as specified in your contract) and are full-time students at an accredited school, college or university.

NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED

**SECTION 6 – PREVIOUS/OTHER COVERAGE INFORMATION**

In order to receive credit for preexisting condition waiting periods information must be provided for the last 12 months of coverage (18 months for late enrollees) for you and any dependents listed. If you have a certificate of prior creditable coverage, please attach a copy to this enrollment application. If more than one plan was in effect, or if information is different for dependents, attach additional pages. (Exception: preexisting information is not required for HMO enrollees). Current coverage information is needed for coordination of benefits purposes if you have other coverage that is not being replaced by this coverage, if approved. If covered by Medicare, please complete Section 7.

PREVIOUS COVERAGE POLICYHOLDER NAME	BIRTH DATE (MM/DD/YYYY) / /	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO APPLICANT	GROUP NO. OR POLICY/ID NO.
EMPLOYER'S NAME	EMPLOYMENT DATE (MM/DD/YYYY) / /	EFFECTIVE DATE (MM/DD/YYYY) / /	WILL COVERAGE BE CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, EXPECTED CANCEL DATE / /	
NAME AND ADDRESS OF OTHER INSURANCE COMPANY, TPA, HMO	TYPE OF COVERAGE <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> EMPLOYER SPONSORED <input type="checkbox"/> INDIVIDUAL PURCHASE		TYPE OF POLICY <input type="checkbox"/> SELF <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILD	

LIST ALL THOSE COVERED BY PREVIOUS/OTHER CARRIER

**SECTION 7 – MEDICARE COVERAGE INFORMATION**

NAME OF PERSON COVERED:	<input type="checkbox"/> MEDICARE A (HOSPITAL) EFFECTIVE DATE: / / <input type="checkbox"/> MEDICARE B (MEDICAL) EFFECTIVE DATE: / /	MEDICARE NO. (FROM MEDICARE CARD)
NAME OF PERSON COVERED:	<input type="checkbox"/> MEDICARE A (HOSPITAL) EFFECTIVE DATE: / / <input type="checkbox"/> MEDICARE B (MEDICAL) EFFECTIVE DATE: / /	MEDICARE 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 – DISABLED DEPENDENT**

NAME OF DISABLED DEPENDENT	NATURE OF DISABILITY
HAS DISABILITY BEEN DIAGNOSED AS PERMANENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF TEMPORARY, HOW LONG IS DEPENDENT EXPECTED TO REMAIN DISABLED?
IS DEPENDENT UNABLE TO WORK DUE TO THE DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS DEPENDENT DEEMED DISABLED BY SOCIAL SECURITY ADMINISTRATION <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE COPY OF THE SOCIAL SECURITY DETERMINATION

**SECTION 9 – DECLINATION OF HEALTH COVERAGE**

I HAVE BEEN OFFERED THE COVERAGE FOR A BLUE CROSS AND BLUE SHIELD OF OKLAHOMA OR BLUELINC'S HMO PLAN AND HAVE ELECTED TO DECLINE COVERAGE UNDER EITHER BENEFIT OPTION. MY COMPLETION OF SECTION 9 DOCUMENTS MY DECISION AND MAY PERMIT ME TO ENROLL IN THE PROGRAM AS A SPECIAL ENROLLEE IN THE FUTURE IN ACCORDANCE WITH FEDERAL REGULATIONS. COMPLETION OF THIS SECTION IS ALSO REQUIRED UNDER THE OKLAHOMA SMALL EMPLOYER HEALTH INSURANCE LEGISLATION. PLEASE READ SECTION 11, NOTICE, AGREEMENTS & SIGNATURES WHICH EXPLAINS TIMELY AND SPECIAL ENROLLEE AND PROVIDE YOUR SIGNATURE AND DATE.

NAME <input type="checkbox"/> EMPLOYEE	REASON FOR DECLINING: <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE <input type="checkbox"/> OTHER GROUP COVERAGE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER, EXPLAIN:
NAME <input type="checkbox"/> SPOUSE	REASON FOR DECLINING: <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE <input type="checkbox"/> OTHER GROUP COVERAGE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER, EXPLAIN:
NAME <input type="checkbox"/> CHILD	REASON FOR DECLINING: <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE <input type="checkbox"/> OTHER GROUP COVERAGE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER, EXPLAIN:
NAME <input type="checkbox"/> CHILD	REASON FOR DECLINING: <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE <input type="checkbox"/> OTHER GROUP COVERAGE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER, EXPLAIN:
NAME <input type="checkbox"/> CHILD	REASON FOR DECLINING: <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE <input type="checkbox"/> OTHER GROUP COVERAGE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER, EXPLAIN:

**SECTION 10 – STATEMENT OF HEALTH**

<b>APPLICANT</b> EXACT HEIGHT: FEET ____ INCHES ____ EXACT WEIGHT: POUNDS ____	<b>SPOUSE</b> EXACT HEIGHT: FEET ____ INCHES ____ EXACT WEIGHT: POUNDS ____
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**MEDICAL QUESTIONNAIRE** Answer these health questions (below) for each person applying for health coverage  
 Directions: Please check  YES or  NO. If any box is checked " YES," circle the condition, e.g. STROKE and give details in "DETAILS OF MEDICAL HISTORY" section below.

1. HAVE YOU OR ANY FAMILY MEMBER APPLYING FOR COVERAGE HAD A CLAIM OF \$5000 OR MORE IN THE LAST 12 MONTHS?  YES  NO
2. HAVE YOU OR ANY FAMILY MEMBER APPLYING FOR COVERAGE BEEN ADVISED TO HAVE SURGERY OR MEDICAL TREATMENT IN THE LAST 6 MONTHS THAT HAS NOT YET BEEN PERFORMED, OR BEEN HOSPITALIZED OR HAD SURGERY IN THE PAST 3 YEARS?  YES  NO
3. HAVE YOU OR ANY FAMILY MEMBER APPLYING FOR COVERAGE BEEN ADVISED, DIAGNOSED OR TREATED IN THE LAST FIVE YEARS FOR:
  - A. STROKE, CIRCULATORY DISEASE OR DISORDER, HIGH BLOOD PRESSURE, HEART DISEASE OR DISORDER, VASCULAR DISEASE OR DISORDER  YES  NO
  - B. CANCER, LEUKEMIA, CHRONIC SKIN CONDITION, TUMORS, LUPUS, ANY OTHER SYSTEMIC DISEASE  YES  NO
  - C. MULTIPLE SCLEROSIS, OSTEOARTHRITIS, JOINT DISORDERS, MUSCLE DISORDERS, PARALYSIS, OTHER SEVERE ARTHRITIS, BACK DISORDERS, BONE DISORDERS  YES  NO
  - D. ASTHMA, RESPIRATORY AND LUNG DISORDERS, EMPHYSEMA  YES  NO
  - E. DIABETES, GROWTH DISORDERS, PANCREAS, ENDOCRINE DISORDER  YES  NO
  - F. AIDS, IMMUNE SYSTEM DISORDERS, TESTED POSITIVE FOR HIV, BLOOD DISORDERS  YES  NO
  - G. HEPATITIS, DIGESTIVE SYSTEM DISEASE OR DISORDER, KIDNEY DISORDER, REPRODUCTIVE ORGANS DISORDER, URINARY TRACT DISORDER, LIVER DISORDER, COLON DISORDER, PROSTATE DISORDER, INFERTILITY  YES  NO
  - H. NERVOUS SYSTEM/BRAIN/SEIZURE DISORDERS, ALCOHOL/DRUG/SUBSTANCE ABUSE OR DEPENDENCY, MENTAL/EMOTIONAL DISORDERS  YES  NO
  - I. ORGAN TRANSPLANT, BONE MARROW TRANSPLANT  YES  NO
  - J. PREGNANCY  YES  NO
  - K. OTHER  YES  NO
4. ARE YOU OR ANY FAMILY MEMBER APPLYING FOR COVERAGE CURRENTLY PREGNANT?  YES  NO

**DETAILS OF MEDICAL HISTORY**

If you have answered "YES" to any of the questions above, please provide details below for each person with the condition. If more than one person has the condition, add a separate entry for each person. See example in the first line. Attach additional sheet if necessary.

NAME OF PERSON WITH CONDITION (OPTIONAL)	AGE	GENDER	RELATION TO INSURED	CONDITION/DIAGNOSIS DETAILS	TREATMENT/MEDICATION DETAILS	DATE(S) TREATED	CURRENT STATUS
John Doe	12	M	Child	Appendicitis	Surgery to remove appendix	01/01/99 to 01/05/99	Full recovery

**SECTION 11 – NOTICE, AGREEMENTS AND SIGNATURES**

**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 dependent(s) because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependent(s) 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 dependent(s), 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(s) 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 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 Blue Cross and Blue Shield of Oklahoma, P.O. Box 3283, Tulsa, OK 74102-3283. 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.



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 am notified of acceptance, in writing, by the Plan.

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.

I understand 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.

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

SIGNATURE OF APPLICANT (EMPLOYEE) I AGREE TO ALL THE TERMS OF THIS APPLICATION  	DATE SIGNED  / /	SIGNATURE OF SPOUSE I AGREE TO ALL THE TERMS OF THIS APPLICATION  	DATE SIGNED  / /
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