South Carolina

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

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Companion Life is a separate life insurance company that does not provide BlueCross BlueShield of South Carolina products or services. Companion Life is solely responsible.

MEMBERSHIP APPLICATION

SM Service Mark of the Blue Cross and Blue Shield Association.

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.** Home Phone: (___) ___-_____ E-mail: ______

7. Name of Employer: ______ **8.** Group No.: ______

9. Dept. No.: ______ **10.** Effective Date of Action Requested: ___/___/___

REASON FOR APPLICATION

11. ☐ New Member – **I am a full-time employee working at least 30 hours per week, 48 weeks per year?** ☐ Yes ☐ No **Full-time Date of Hire:** ___/___/___

☐ Coverage Change – Reason for Change: ______ Date of Occurrence: ______

☐ Late Enrollee ☐ Address Change ☐ Beneficiary Change ☐ Cancellation – Date Left Employment: ___ / ___ / ___

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

☐ COBRA Qualifying Event: ______ Start Date: ___/___/___

☐ State Continuation – Start Date: ___/___/___

☐ Sponsored Membership – Sponsored Member's Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

COVERAGE INFORMATION

Plan Offered by Employer: Business Blue^SM Complete (Preferred Blue) ☐ PPO ☐ HDHP ☐ HDHRA; Business Blue^SM Secure ☐; Business Blue^SM Basic ☐

12. MEDICAL ELECTION

☐ Employee Only ☐ Employee/Spouse

☐ Employee/Child(ren) ☐ Family

☐ No Medical Coverage due to: (Check one)

- ☐ Other BlueCross BlueShield of SC Coverage (01)
- ☐ Covered by Military (03)
- ☐ Insurance with Another Company (02)
- ☐ Covered by Medicare (12)
- ☐ Covered by Spouse with this Employer (07)
- ☐ Other (05) (Explain) ______

13. DENTAL ELECTION *Business Blue Complete (Preferred Blue, HDHP and HDHRA) Only*

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

14. LIFE COVERAGE (underwritten by Companion Life)

☐ Life Only (No Medical) ☐ Life and AD&D ☐ Dependent Life ☐ STD ☐ LTD

Life Amount $______ Life Class______

Earnings $______ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Beneficiary Designation *(All Plans - applicable only if Life Coverage is available and selected)*

Primary: ______ Relationship: ______

Contingent: ______ Relationship: ______

ENROLLMENT INFORMATION (List all individuals to be covered.)

15.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Full-Time Student*
Spouse						☐ Yes ☐ No
Child					N/A	☐ Yes ☐ No
Child					N/A	☐ Yes ☐ No
Child					N/A	☐ Yes ☐ No
Child					N/A	☐ Yes ☐ No

(*Age 19 through 22 Only) Please attach Registrar's letter or tuition receipt showing credit hours. This is required before coverage can become effective for this dependent.)

OTHER COVERAGE INFORMATION

16. Other than your coverage with this employer, do you or any of your family members have other health (including Medicare), dental or drug coverage? ☐ Yes ☐ No

If yes and the policy is with Blue Cross and Blue Shield of South Carolina, please indicate the Policyholder's ID Number: ______

17. Did you or any of your family members have health or dental coverage in effect prior to your coverage under this policy? ☐ Yes ☐ No

If yes, please attach a copy of the applicable Certificate of Coverage or other proof so that we can determine if you are eligible for credit toward your waiting period for pre-existing conditions.

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

I hereby authorize the release of any medical or non-medical information about myself or eligible or enrolled dependents by any insurance company, medical professional, medical institution or other healthcare provider concerning the diagnosis, the treatment, and prognosis of any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, to include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations 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 twelve months, then subject to pre-existing conditions for six months.

Signature: ______ **Date:** ______