BlueCross BlueShield of Connecticut
An independent licensee of the Blue Cross and Blue Shield Association

Enrollment and Membership Change Form

1. Tell Us About You

Current BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( ) | Work Telephone ( )

MARITAL STATUS: ○ Single ○ Married ○ Legally Separated ○ Separated ○ Widowed ○ Divorced

2. New Membership

○ NEW HIRE
○ OPEN ENROLLMENT
○ COBRA/C.G.S. 38a-538
DATE OF QUALIFYING EVENT / /
REASON ______ SEE INSTRUCTION SHEET

3. Change Membership

CHANGE:
○ ADDRESS
○ NAME
○ OTHER
REASON ______
DATE / /

4. Your Membership Choices

	Individual	Two Person	Family
☐ BLUECARE	☐	☐	☐
☐ CENTURY PREFERRED	☐	☐	☐
☐ DENTAL	☐	☐	☐
☐ HMO--NEW ENGLAND	☐	☐	☐
☐ OTHER	☐	☐	☐

Are you, your spouse or any dependent children currently confined to a hospital or other healthcare facility, or totally disabled? ○ YES ○ NO

To Be Completed By Employer

Requested Effective Date / /

Firm Division No.

Health Benefit Plan

For Office Use Only

5. Where You Work

COMPANY NAME

ARE YOU ACTIVELY AT WORK? ○ YES ○ NO / REASON

DO YOU WORK 30 OR MORE HOURS PER WEEK? ○ YES ○ NO

DATE OF FULL TIME HIRE / / | DATE OF PART TIME HIRE / / | DATE OF REHIRE / /

6. List Family Members To Be Added/Cancelled

	First Name	M.I.	Last Name	Add	Cancel	Social Security No.	Date of Birth (MM/DD/YR)	Full Time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory) Check ☑ the box if you currently use this physician.
SELF ○ M ○ F				○	○		/ /			Name First Last ☐ City PCP Provider No.
SPOUSE ○ M ○ F				○	○		/ /			Name First Last ☐ City PCP Provider No.
DEPENDENTS: Children over 19 may be eligible if disabled or unmarried full time students ☐ Check if any dependents are disabled										
DEPENDENT ○ M ○ F				○	○		/ /	Y N ○ ○		Name First Last ☐ City PCP Provider No.
DEPENDENT ○ M ○ F				○	○		/ /	Y N ○ ○		Name First Last ☐ City PCP Provider No.
DEPENDENT ○ M ○ F				○	○		/ /	Y N ○ ○		Name First Last ☐ City PCP Provider No.
DEPENDENT ○ M ○ F				○	○		/ /	Y N ○ ○		Name First Last ☐ City PCP Provider No.

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or BCBS coverage? ○ YES ○ NO If yes, please fill in the information below. ○ Self ○ Spouse ○ Children

Name of Other Insurance Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason For Termination	First and Last Date of Coverage

8. Medicare

Do you or any covered family member have Medicare coverage? ○ YES ○ NO

Name (Self) | Are you actively at work? ○ YES ○ NO | Retirement Date / /

Medicare No. | Effective Dates: Medicare A (Hospital) / / | Medicare B (Medical) / /

Name (Dependent) | Is this person actively at work? ○ YES ○ NO | Retirement Date / /

Medicare No. | Effective Dates: Medicare A (Hospital) / / | Medicare B (Medical) / /

I apply for coverage (or change in coverage) as specified above and authorize my employer to deduct any required premium contributions from my pay. I understand that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document, which is incorporated by reference herein.
I authorize Blue Cross & Blue Shield of Connecticut or any physician, hospital, insurer or any organization or person having records, data or information about me or my family's health or medical history or benefits, including those related to HIV/AIDS, psychiatric care or drug or alcohol use, to furnish such records, data or information as may be requested by or of Blue Cross & Blue Shield of Connecticut for use in connection with health benefits or claims related thereto. Such authorization shall further apply to the release of my or my family's records, data or information to contractors, agents or representatives of Blue Cross & Blue Shield of Connecticut if they agree to keep it confidential. A copy of this authorization shall be as effective as the original.
I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my dependents.
I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date / /

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