Application and Change Form

BlueCross BlueShield of Wyoming

An independent licensee of the Blue Cross and Blue Shield Association.

When completing this application, please PRINT using BLACK ink. Initial all corrections; do not use correction fluid or correction tape.

Complete all sections that apply.
Incomplete applications will be returned, and this may result in a later effective date of coverage.

You are applying for coverage that contains comprehensive adult wellness benefits as defined by the Wyoming Insurance Code. For a further description of these benefits, please refer to the Benefits Section of your Group Master Agreement.

SECTION 1. EMPLOYEE INFORMATION

Employee Name: First ______ M.I. ___ Last ______

☐ Married ☐ Single
Marital Status

Home Address ______

City ______ State ___ Zip ______ +4 ____

Home Telephone Number ______ Office Telephone Number ______

Full Company Name ______

Position Title ______

Date Employed 30+ Hrs (MM-DD-YY) (By this Company) ___ ___ ___

Type of Employment:
☐ Hourly ☐ Salaried

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

SECTION 2. REASON FOR COMPLETION OF APPLICATION

☐ New Coverage (Complete ALL sections of application)

☐ Enrolling for Coverage that I previously declined (Complete ALL sections of application)
Reason:
☐ COBRA coverage exhausted ☐ Newborn
☐ Lost coverage through spouse's/parent's employer ☐ Adoption
☐ Spouse's/parent's employer no longer contributes to premium ☐ Marriage
Date of Event: ______

TYPE OF ENROLLMENT (Check One)
☐ Self Only
☐ Self and One or More Children
☐ Self and Spouse
☐ Self, Spouse and One or More Children

☐ Change in Coverage:

Current I.D. Number ______

☐ **Add Dependent. Complete ALL sections of Application**
☐ Marriage: Date ______
☐ Birth: Date ______
☐ Adoption: Date ______
☐ Court Order: Date ______
☐ Other: ______

☐ **Remove Dependent who is currently covered (Complete only Sections 1 & 2)**

Remove Coverage For:

Name	Date of Birth

☐ Marriage: Date ______
☐ Divorce: Date ______
☐ Separation: Date ______
☐ Death: Date ______
☐ Receiving Coverage Elsewhere: Date: ______
☐ Other: ______

Signature: ______ Date: ______

For Blue Cross Blue Shield Office use Only

Class______ GRP/Roll______ AD______ Probationary Period______

OED______ BCBS______ DSC______

204SG

SECTION 3. FAMILY MEMBER INFORMATION

1. If adding a dependent(s) to your coverage, complete this section for ONLY the individual(s) you are adding.
2. For a new application, list self, spouse, and all children. The application must be received no later than 30 days after the completion of your Probationary Period, or you may be subject to late en
3. By declining coverage, you may be subject to the late enrollee penalties as stated in the Group Master Agreement. If you are declining coverage for yourself, spouse and/or children because of (special enrollment rights.
4. Dependents (spouse and/or children) are eligible as defined in the Group Master Agreement.

	Employee	Spouse	Child
Name			
Social Security Number			
Gender	Male Female	Male Female	Male Female
Date of Birth			
Other Coverage Still in Force?	Yes No	Yes No	Yes No
Name of Insurance Company			
Policy #			
Date Coverage Began			
If Group Coverage; Name of Employer			
Enrolling or Declining Coverage?	Enroll Decline	Enroll Decline	Enroll Decline
Name of School if Applicable	XXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXX	
Height	Ft. In.	Ft. In.	Ft. In.
Weight	lbs.	lbs.	lbs.
Social Security Disabled?	Yes No	Yes No	Yes No
Active Military?	Yes No	Yes No	Yes No
Other Prior Coverage	Yes No	Yes No	Yes No
Name of Insurance Company			
Policy #			
Date Coverage Began			
Date Coverage Ended			

SECTION 4. HEALTH HISTORY: Indicate if YOU or ANYONE ENROLLING FOR COVERAGE has ever had, or presently has, any problems related to the following. Plea

	Y	N	
1.	☐	☐	AIDS (Acquired Immune Deficiency) or ARC (AIDS Related Complex)
2.	☐	☐	Alcohol or Chemical Dependence
3.	☐	☐	Blood Disease
4.	☐	☐	Cyst, Growth, Tumor or Polyp of any kind ☐ Benign ☐ Malignant
5.	☐	☐	Respiratory (lung) Disorders: Allergy or Hay Fever, Asthma, Bronchitis, Emphysema, Pneumonia, Tuberculosis
6.	☐	☐	Neurological Disorders: Alzheimer's, Epilepsy or Seizures, Migraines, Multiple Sclerosis, Paralysis, Parkinson's, Stroke
7.	☐	☐	Musculoskeletal Disorders: Arthritis or Rheumatism, Disorders of the Back, Joints or Neck
8.	☐	☐	Circulatory Disorders: Chest Pain, Heart Disease, High Cholesterol, Varicose Veins
9.	☐	☐	Congenital Birth Defects
10.	☐	☐	Depression, Psychiatric Disorders
11.	☐	☐	Diabetes
12.	☐	☐	Disorders of the Eye, Ear, Nose or Throat
13.	☐	☐	Disorders of the Bladder, Intestine, Kidney, Liver, Ureters
14.	☐	☐	Female Reproductive Disorders

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE RECORD ITEM # AND GIVE DETAILS BELOW

Item #	Person Affected	Name of Disease, Symptom, or Condition	Date of Onset	Treatment for Condition	Medication (list dose, frequency, duration)

IF ADDITIONAL SPACE IS REQUIRED, PLEASE

penalties as stated in the Group Master Agreement.
iealth insurance coverage, you may be able to apply in the future under special enrollment. Failure to specify now that you are declining coverage because you have other coverage may waive your

Child	Child	Child	Child
Male Female	Male Female	Male Female	Male Female
Yes No	Yes No	Yes No	Yes No
Enroll Decline	Enroll Decline	Enroll Decline	Enroll Decline
Ft. In.	Ft. In.	Ft. In.	Ft. In.
lbs.	lbs.	lbs.	lbs.
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No

eck "Yes" or "No" for each item 1 through 28 below.

	Y	N	
15.	❑	❑	Immune Disorders
16.	❑	❑	Organ Transplantation
17.	❑	❑	Prostate Disorder
18.	❑	❑	Skin Condition
19.	❑	❑	High Blood Pressure: If yes, Latest Reading __________(systolic) / __________(diastolic) Date of Reading:______________________
20.	❑	❑	Are you or any dependent currently pregnant? Due Date:__________________________
21.	❑	❑	Do you or any dependent currently, or have you or any dependent, used tobacco products in the past 5 years?
22.	❑	❑	Have you or any dependent used illegal drugs?
23.	❑	❑	Do you or any dependent use alcohol? Frequency____________________
24.	❑	❑	Have you or any dependent tested positive for exposure to Human Immunodeficiency Virus (HIV)?
25.	❑	❑	Are you or any dependent currently on Medication?
26.	❑	❑	Has anyone ever had health coverage denied or cancelled?
27.	❑	❑	Has anyone had any other Medical, Surgical or other disorder?
28.	❑	❑	Have you or any dependent been absent from work for two consecutive weeks due to illness or injury during the past two years or are you or any dependent receiving disability benefits of any type?

Surgeries/Operations Required or Recommended for Condition	Date of Surgeries	Date of Recovery	Name of Physician	Physician Address

ACH THE SUPPLEMENTAL INFORMATION FORM

SECTION 5. MEDICARE INFORMATION

If any person listed on this application is covered by Medicare, please complete the following:

Employee Name | Medicare Beneficiary Number | Date of Medicare Entitlement: Part A | Part B

Reason for Medicare Entitlement (age/disability/ESRD) | If your Medicare coverage has terminated, please state reason | Date of termination

Dependent Name | Medicare Beneficiary Number | Date of Medicare Entitlement: Part A | Part B

Reason for Medicare Entitlement (age/disability/ESRD) | If your Medicare coverage has terminated, please state reason | Date of termination

SECTION 6. PLEASE READ CAREFULLY. EMPLOYEE SIGNATURE REQUIRED

I understand that, upon acceptance of this application, coverage will become effective on the date established by Blue Cross Blue Shield of Wyoming and that this application and attachments, if any, will become part of the agreement between Blue Cross Blue Shield of Wyoming and my employer.

I authorize my employer to deduct from my wages and remit to Blue Cross Blue Shield of Wyoming the amount of dues for which I am liable, if any. As proof of status of employment, I authorize my employer to release to the insurer appropriate documents, including but not limited to, W-2 Wage and Tax Statements and other wage and tax summaries or forms.

PRE-EXISTING CONDITIONS: Participants are subject to all pre-existing conditions exclusions (as stated in the Group Master Agreement) which conform to Federal and State requirements regarding pre-existing condition exclusion periods, including the definition of pre-existing conditions and the portability of pre-existing condition exclusion periods. In the event a pre-existing condition exclusion applies, the time the participant was previously covered by public or private health insurance, or other health benefit arrangements will be credited provided there was not a significant break (as defined in the Group Master Agreement) in coverage from the previous creditable coverage. Late enrollees (who apply more than 30 days after their initial eligibility and who are not eligible for a special enrollment period as provided by applicable law) will only be able to enroll during the group's annual open enrollment period. In addition, late enrollees will be subject to a pre-existing conditions exclusion as defined in the Group Master Agreement.

I AFFIRM THAT I HAVE REVIEWED ALL ANSWERS GIVEN ON THIS APPLICATION AND, REGARDLESS OF WHETHER ANY OTHER PERSON HAS FILLED OUT THE ANSWERS FOR ME, I VERIFY THAT THE ANSWERS ARE TRUE AND COMPLETE, THAT THE STATEMENTS MADE ON THIS APPLICATION ARE TRUE, THAT THIS APPLICATION CORRECTLY SETS FORTH THE HEALTH STATUS OF ALL PERSONS LISTED ON THIS APPLICATION, AND THAT EACH PERSON ENROLLING FOR COVERAGE IS IN GOOD HEALTH EXCEPT AS EXPRESSLY NOTED ON THIS APPLICATION.

I REALIZE THAT ANY ACT, PRACTICE, OR OMISSION I HAVE PERFORMED THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT ASKED FOR ON THIS APPLICATION WILL RENDER THE CONTRACT NULL AND VOID OR SUBJECT TO CANCELLATION, RESCISSION, OR TO DISALLOWANCE OF THE PERSON ABOUT WHICH THE FRAUDULENT ACT, PRACTICE, OMISSION, OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT OCCURRED.

I HAVE READ AND I UNDERSTAND THE ABOVE ITEMS. I hereby apply for and/or decline coverage for myself and/or my dependent(s) as indicated in Section 3. with Blue Cross Blue Shield of Wyoming under the terms and conditions as stated in the Group Master Agreement.

EMPLOYEE SIGNATURE:______________________ DATE:______________

APPLICATION WILL NOT BE PROCESSED IF RECEIVED MORE THAN 60 DAYS AFTER DATE OF SIGNATURE

SECTION 7. MUST APPLY FOR OR DECLINE LIFE INSURANCE

EMPLOYEE DATE OF BIRTH____/____/____ NON-MEDICAL COVERAGE EFFECTIVE DATE____/____/____

Basic Life / AD&D ☐ Yes ☐ No Dependent Life ☐ Yes ☐ No STD Benefit ☐ Yes ☐ No LTD Benefit ☐ Yes ☐ No

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). **If you list benefit percentages, the total must equal 100%.** (Employee is the beneficiary of proceeds from spouse or child coverage.)

BENEFICIARY First Name Last Name	Date of Birth	Relationship	Social Security #	Benefit %
Primary				%
Primary				%
Contingent				%

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy(ies) issued to the employer listed above. I understand that if I am not actively at work, as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work For those coverages I have declined, I understand that if I choose to enroll at a later date my cost may be higher and a health questionnaire may be required.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Signature:______________________ Date:______________