SAMFORD UNIVERSITY
BENEFITS ENROLLMENT

BlueCross/BlueShield - Medical, Dental, Vision & Rx

☐ I apply for the Group Health Benefits for which I am eligible.

☐ I have been given the opportunity to apply for Group Health Benefits and **I decide not to apply** at this time. I understand if I later make application for insurance, it must be done either during the annual open enrollment period or a qualifying life event.

☐ I am cancelling my Group Health Benefits.

☐ I am making changes to my existing Group Health Benefits.

Nature of Change: ☐ Name Change ☐ Add Dependents ☐ Remove Dependents

Qualifying Event: ☐ New Hire ☐ Open Enrollment ☐ Marriage
☐ Birth/Adoption ☐ Loss of Coverage ☐ Other

Date Event Occurred:_____ Other explanation: _____

Effective Date of Change:_____

PERSONAL INFORMATION			
EMPLOYEE NAME: (LAST) (FIRST) (MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYY)	
STREET ADDRESS: CITY: STATE: ZIP:	PHONE NUMBER ( ) -		
CHECK ONE: ☐ MALE ☐ FEMALE	CHECK ONE: ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED	TYPE OF COVERAGE SELECTED: ☐ INDIVIDUAL ☐ FAMILY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILDREN	

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER

ACTION	RELATIONSHIP	LAST NAME FIRST NAME MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)
☐ ADD ☐ REMOVE	☐ HUSBAND ☐ WIFE			
☐ ADD ☐ REMOVE	☐ SON ☐ DAUGHTER			
☐ ADD ☐ REMOVE	☐ SON ☐ DAUGHTER			
☐ ADD ☐ REMOVE	☐ SON ☐ DAUGHTER			
☐ ADD ☐ REMOVE	☐ SON ☐ DAUGHTER			
☐ ADD ☐ REMOVE	☐ SON ☐ DAUGHTER			

*** Please add additional dependents on separate sheet**

Rev. 12/2020

COORDINATION OF BENEFITS INFORMATION		
If you, your spouse, or your dependents are covered by any other group health insurance, please give the following:		
NAME OF CONTRACT HOLDER/DEPENDENT		POLICY ID, CONTRACT, OR CERTIFICATE NUMBER
NAME OF INSURANCE COMPANY	TYPE OF COVERAGE □ INDIVIDUAL □ FAMILY	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)
EMPLOYER'S NAME:		GROUP NUMBER

MEDICARE BENEFITS INFORMATION		
If you, your spouse, or your dependents are covered by Medicare, please give the following:		
LAST NAME FIRST NAME INITIAL		MEDICARE NUMBER
PART A EFFECTIVE DATE (MM/DD/YYYY)	PART B EFFECTIVE DATE (MM/DD/YYYY)	PART D EFFECTIVE DATE (MM/DD/YYYY)

My application is subject to the terms and conditions of the agreement between my group (organization through which I am applying for coverage) and you (Blue Cross and Blue Shield). If you accept this application, you will send me an ID card. My group's contract with you is made up of 1) My group's application to you; 2) The group health benefits certificate or group agreement, and 3) Any written amendments to the certificate or group agreement. My contract with you is made up of these 3 items and this and any later application made by me to you. My coverage will be through this contract, I name my group as my group agent or remitting agent. I ask my group to pay you direct and I give my group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask my doctor, hospital or anyone else to give all medical records of my family or me to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of your claims.

I will cooperate with you. If you need any information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information.

I understand that if I do not enroll within 30 days of my initial eligibility or as a special enrollee, I am a late enrollee and will be required to serve an 18-month exclusion period (unless otherwise stated by your plan) for pre-existing conditions.

Signature of Employee:_____ Date: _____