Carolina ADVANTAGE

Enrollment Application and Change Form

Important Instructions

Coverage does not become effective under any circumstances until an application has been approved by BlueChoice HealthPlan.

- Please print in ink or type.
- The application must be completed in full and signed where indicated.
- Completed application must be received by BlueChoice HealthPlan's Membership Department within 30 days from the signature date and sent to BlueChoice HealthPlan, Membership Department, AX-425, P.O. Box 6170, Columbia, S.C. 29260-6170.

INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).

B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.

C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.

D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.

E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.

BlueChoice HealthPlan is a wholly owned subsidiary of BlueCross BlueShield of South Carolina.
Both are Independent Licensees of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.
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ENROLLMENT APPLICATION AND CHANGE FORM

Companion Life Insurance Company
Life, Disability

New Enrollment ☐
Effective Date ______

Change ☐
Effective Date ______

INTERNAL USE ONLY
Pre-X Date ______

A. IF MAKING A CHANGE

ENROLLMENT CHANGE DATE DUE TO

☐ Marriage ☐ Birth/Adoption ☐ Termination ☐ COBRA Applicant – Start Date ______ End Date ______
☐ Death ☐ Address Change ☐ Other ______

B. TO BE COMPLETED BY ALL EMPLOYEES

1. Employee Actively At Work ☐ COBRA ☐ Retired ☐
2. Social Security No. ___ - __ - ____
3. Employee – Last Name First
Date of Birth MM - DD - CCYY
Sex Male ☐ Female ☐
4. Mailing Address Street or P.O. Box City State ZIP Code
5. Home Phone ___ - ___ - ____ Work Phone ___ - ___ - ____
6. E-Mail Address:
7. Name of Employer
8. Full-time Date of Hire

Job Title or Description | BlueChoice HealthPlan Group Number | Dept. No. | Payroll No.

C. MEMBERSHIP AND COVERAGE INFORMATION

Check for Type of Contract: ☐ Standard ☐ HDHP

	Medical	Comprehensive Dental
S – Single	☐	☐
F – Employee/Spouse/Children	☐	☐
D – Employee/Children	☐	☐
8 – Employee/Spouse	☐	☐
0 – No Benefits	☐	☐

Reason for Waived Coverage:
☐ Insurance with another company
☐ Covered by spouse with this employer
☐ Other - Explain ______

D. COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

List all Family Members To Be Covered or Affected By a Change. Do Not Use Nicknames.

	Last Name	First	Sex	Date of Birth Mo.	Day	Yr.	Social Security No.	Height	Weight
Yourself							- -		
Spouse							- -		
Child							- -		
Child							- -		
Child							- -		
Child							- -		

Life and/or Disability coverage is provided by Companion Life Insurance Company

Companion Life is a separate life insurance company that does not provide BlueChoice HealthPlan products or services. Companion Life is solely responsible.

Types and Amounts of Coverage Requested:

☐ Life $ ______
☐ AD & D $ ______
☐ Dep. Life $ ______
☐ STD $ ______
☐ LTD $ ______

Earnings:
$______
(Amount)

(Check One)
☐ Hourly
☐ Weekly
☐ Biweekly
☐ Monthly
☐ Annually

Life Class

List Primary Beneficiary(ies) (Last Name, First, Middle Initial) Relationship

Primary Beneficiary(ies) ______

Contingent Beneficiary ______

☐ **Life Only (Life insurance coverage is provided by Companion Life Insurance Company)**

E. OTHER INSURANCE INFORMATION

Are you or any dependents to be covered by this policy enrolled in Medicare? ☐ Yes ☐ No

If yes: ☐ Medicare A - Effective Date_____/____/_____ ☐ Medicare B - Effective Date_____/____/_____

Name of Person(s)____________________ Name of Person(s)____________________

Does anyone being covered by this policy have any other Health, Dental or Drug coverage? ☐ Yes ☐ No If Yes, complete this section.

Policyholder's Name ____________________ ID Card Number ____________________

Name of Insurance Co. ____________________ Policy No. ____________ Effective Date ___/___/_____

Policyholder's Employer ______________________________

List All Persons Covered 1________________ 2 ________________ 3 ________________

Indicate type of services covered by this policy: ☐ Hospital ☐ Physician/Medical ☐ Prescription Drugs ☐ Dental

F. HEALTH INFORMATION TO BE COMPLETED BY ALL EMPLOYEES

Please complete the following questions for you or any dependents to be covered:

a. In the last 12 months has any person had in excess of $2,500 medical expenses? ☐ Yes ☐ No

b. In the last 3 years has anyone been denied insurance for health reasons or been issued an exclusion rider? ☐ Yes ☐ No

c. Are you or your spouse now pregnant? If yes, provide expected delivery date:________________. ☐ Yes ☐ No

d. Is there a history of infertility, complicated pregnancy, multiple births, premature birth or sick newborn? ☐ Yes ☐ No

e. Is any person currently disabled or not actively at work? ☐ Yes ☐ No

f. Has any individual to be enrolled taken prescription drugs in the last 12 months? ☐ Yes ☐ No

g. Within the last 10 years has any person been hospitalized, had surgery, consulted or been treated by a physician for an injury or illness other than flu, colds, sore throat or routine checkups? ☐ Yes ☐ No

h. Has any person used any form of tobacco or nicotine substitute in the last 12 months? ☐ Yes ☐ No

If you answered yes to any of the above questions, please provide the dates and details below in the next section.

SEPARATE PERSONAL HEALTH STATEMENTS MUST ALSO BE COMPLETED FOR GROUPS WITH 2-19 ELIGIBLE EMPLOYEES.

G. HEALTH INFORMATION DETAILS

Patient's Name	Doctor's Name, Address & Phone #	Condition	Dates	Treatment/Medication	Results/Prognosis
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

AUTHORIZATION TO RELEASE INFORMATION AND STATEMENT OF UNDERSTANDING

I hereby authorize the release of any medical or non-medical information about me or my eligible or enrolled dependents by any insurance company, medical professional, medical institution or other healthcare provider concerning the diagnosis, 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 that the benefits for which I (we) will be eligible are those disclosed in the group contract between BlueChoice HealthPlan 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 or Incontestability Provision. All statements made herein are complete and true to the best of my knowledge.

I HAVE READ AND FULLY UNDERSTAND EACH AND EVERY PART OF THIS APPLICATION FOR INSURANCE.

Applicant's Signature ______________________________ Date ________________

GENERAL NOTICE OF PRE-EXISTING CONDITION LIMITATION
APPLIES TO BLUECHOICE HEALTHPLAN MEDICAL BENEFITS ONLY

This plan may contain a pre-existing condition exclusion. This means that if you have 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, you might have to wait a certain period of time before that plan will provide coverage for that condition. This six-month period ends the earlier of the day before your coverage becomes effective (the effective date) or if you were in a waiting period for coverage, the day before the waiting period begins (the enrollment date). The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

BlueChoice HealthPlan
Member Services Department
Post Office Box 6170
Columbia, SC 29260-6170
or call
1-866-858-3272
or 803-382-5309 in Columbia