Medical Enrollment Form
Active Employees

Office use only:

Group number: 004007822 Section code: ____________

Section 1: Employee information

Last name	First name	Middle initial	Social Security no. (required)
Date of birth (MM/DD/YYYY)	Phone no.	Email address	BSU ID no.	Effective date (MM/DD/YYYY)
Street address	City	State	ZIP code

Section 2: Coverage level

Select coverage level and tier below by checking the appropriate box below, OR waive medical coverage.

Reason for application

☐ New enrollment ☐ Annual open enrollment ☐ New hire ☐ Rehire (date): ____ (MM/DD/YYYY)
☐ Add dependent (See section 3) ☐ Qualifying event ☐ CANCEL **HEALTH** for all members ☐ Waiver

Status/event change

The effective date of coverage for a status/event change shall be the Event Date if enrollment is received within 31 days of the status/event change.

Event date: ____ (MM/DD/YYYY)

☐ Marriage [1] ☐ Divorce [1] ☐ Birth [1] ☐ Adoption [1] ☐ Legal guardianship [1] ☐ Court order [1] ☐ Gain/loss of other coverage [1]

☐ Other: ______________________________

1 Including supporting documentation.

Type of coverage plan

☐ Low-Deductible PPO (004) ☐ High-Deductible Wellness PPO (003) ☐ HSA-Qualified Health Plan (002)

Enroll

☐ Myself ☐ Spouse ☐ Child(ren) ☐ Other dependents [2]

2 Must be designated as a dependent on your Federal Income Tax Return to qualify for coverage.

Section 3: Additional information

Do you have other coverage? ☐ Yes ☐ No	Policyholder name	Policy/certificate no.
Name of person(s) covered	Coverage effective date	Date of termination of coverage	Social Security no.
Name of employer	Name of carrier
Street address of carrier	City	State	ZIP code

Section 4: Dependent information

Is dependent's address different than employee's address? If yes, please provide full address below.

☐ Enroll ☐ Waive ☐ Cancel	Last name	First name	Middle initial	Date of birth (MM/DD/YYYY)
	Street address	City	State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	OR	☐ Dependent who is designated as a dependent on my Federal Tax return

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Section 4: Dependent information (continued)

☐ Enroll ☐ Waive ☐ Cancel	Last name		First name		Middle initial	Date of birth (MM/DD/YYYY)	
	Street address		City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my Federal Tax return		
☐ Enroll ☐ Waive ☐ Cancel	Last name		First name		Middle initial	Date of birth (MM/DD/YYYY)	
	Street address		City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my Federal Tax return		
☐ Enroll ☐ Waive ☐ Cancel	Last name		First name		Middle initial	Date of birth (MM/DD/YYYY)	
	Street address		City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my Federal Tax return		
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	Street address		City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my Federal Tax return		
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	Street address		City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my Federal Tax return		

Section 5: Authorization

If a court decree requires to you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form. Please note that Social Security numbers are required on all covered dependents. THIS IS A REQUIREMENT UNDER FEDERAL LAW.

Important note to employees covering a spouse. Our Working Spouse provision became effective on January 1, 2013 and if your spouse is all of the following, you cannot cover them as a dependent unless he or she is also enrolled in the employer's group health plan.

- Working full-time.
- His or her employer offers group health coverage.
- The employer funds at least 60% of the coverage.

It is important if your spouse has a change in employment that you complete and submit an updated Working Spouse Affidavit. For those employees whose spouse's employer refuses to extend coverage to them outside of Open Enrollment, it is important that your spouse enroll in their employer's primary medical coverage at the first available opportunity.

Employee signature: Sign, date, and return this form to Payroll and Employee Benefits — ADG29 to implement the above enrollment/changes.

I hereby request coverage under the group policy offered by employer and I authorize my employer to deduct from my earnings any required contributions. I am an eligible employee working the required hours for my employer. I hereby authorize hospitals, physicians, or other providers of service, including a BSU sponsored wellness program, to furnish Anthem Blue Cross and Blue Shield or its agents, upon request, any and all reports, records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependent together with like reports, records or copies thereof for all earlier services. I further understand that changes to enrollment are generally not permitted during the year, except during a Qualified Open Enrollment Period. However, if I have a change in family status I may make changes such as adding a new spouse or new baby, within 31 days of the event.

Employee signature	Date (MM/DD/YYYY)	Employer approval signature	Date (MM/DD/YYYY)
X		**X**	