

**Section 1. EMPLOYEE INFORMATION**

Employee last name	Employee first name	M.I.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social security no.
Home address		City	State	ZIP code
Home phone no.	Date of hire (MM/DD/YYYY)		Effective date or date of qualifying event	
Medical group no.	Name of institution			

**Section 2. CHANGES – COMPLETE FOR CHANGES TO EXISTING MEDICAL/DENTAL COVERAGE**

Additions		Deletions		Cancel employee	Name change/correction
Person(s)	Reason	Person(s)	Reason	Coverage	
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Dependent child ineligible <input type="checkbox"/> Divorce <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Previous name: _____  Corrections: _____

**Section 3. COVERAGE DESIRED**

Medical plan coverage		Dental plan coverage	
<input type="checkbox"/> BlueAdvantage Point-of-Service (HMO/POS) <input type="checkbox"/> Anthem Blue Cross and Blue Shield PRIME (PPO)	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Anthem Blue Dental PPO Plus (formerly BlueClassic) <input type="checkbox"/> Anthem Blue Dental PPO (formerly BluePreferred)	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Family

**Section 4. LIST OF ELIGIBLE DEPENDENTS – LIST SELF AND ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER. USE SEPARATE SHEET IF NEEDED.**

Name (Last, First, M.I.)	Relationship	Sex	Social security no.	Date of birth	Primary Care Provider Name (Must complete for BlueAdvantage POS)	Provider no.	Current Patient
	SELF	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Y <input type="checkbox"/> N

If you and your spouse are using different last names check applicable box  
 Common law marriage (Attach copy of Affidavit of Common-law Marriage)  Spouse retaining name  Domestic partner retaining name

**Other insurance**

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied for coverage?  
 Yes  No. If yes, complete the section below for all members.

Member name	Carrier	Start date	End date

