BlueCross BlueShield of Delaware

The Benefits Connection

ENROLLMENT / CHANGE APPLICATION

REASON FOR APPLICATION: +Vision

☐ Open Enrollment ☐ New Hire ☐ Birth/Adoption ☐ Marriage ☐ Loss of coverage ☐ Other (specify): Date of event:

Please Print: EMPLOYER NAME	NCC CODE	DATE OF HIRE		EFF. DATE	BCBSD GRP. #	SUB GRP. #
		/ /	☐ Full-time ☐ Retiree ☐ Part-time	/ /	120501	

EMPLOYEE FIRST NAME	M.I.	LAST NAME	HOME PHONE	WORK PHONE
			( )	( )

YOUR STREET ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS

YOUR SOCIAL SECURITY NUMBER / YOUR DATE OF BIRTH—Month, Day, Year			MEDICAL OPTIONS (check one)	EMPLOYEE PCP NAME AND ID NUMBER
	☐ Male ☐ Female	☐ Single ☐ Married	☐ Brandywine Plan (IPA 15) ☐ Chesapeake Plan (EPO) ☐ HSA EPO Plan ☐ Christiana Plan (IPA 10) ☐ HRA EPO Plan ☐ Small Business Value Plan (HSA IPA) ☐ Special **Medicfill**®' Plan (Medicare Supplement)	☐ This is employee's current PCP.

I WOULD LIKE COVERAGE FOR MY DEPENDENTS AND MYSELF. PLEASE PRINT ALL REQUESTED INFORMATION.	DATE OF BIRTH	RELATIONSHIP TO APPLICANT	DEPENDENT'S SOCIAL SECURITY NUMBER	GENDER	PCP'S NAME AND PROVIDER ID NUMBER	FULL-TIME STUDENT?	DIS-ABLED?
DEPENDENT'S FIRST NAME M.I. LAST NAME (if different) ☐ Add ☐ Delete	/ /			☐ M ☐ F	☐ This is dependent's current PCP.	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT'S FIRST NAME M.I. LAST NAME (if different) ☐ Add ☐ Delete	/ /			☐ M ☐ F	☐ This is dependent's current PCP.	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT'S FIRST NAME M.I. LAST NAME (if different) ☐ Add ☐ Delete	/ /			☐ M ☐ F	☐ This is dependent's current PCP.	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT'S FIRST NAME M.I. LAST NAME (if different) ☐ Add ☐ Delete	/ /			☐ M ☐ F	☐ This is dependent's current PCP.	☐ Yes ☐ No	☐ Yes ☐ No

CURRENT HEALTH CARE COVERAGE. If you or a dependent listed above has other insurance under a group plan or HMO, please provide the following information:

NAME OF INSURED	ID NUMBER	ACCOUNT NUMBER	INSURANCE COMPANY

MEDICARE COVERAGE. If you or a dependent listed above has Medicare coverage, please provide the name and Medicare number:

NAME	MEDICARE NUMBER	PART A HOSPITAL DATE	PART B MEDICAL DATE

TERMS OF AGREEMENT. It is understood that: **(1)** Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and Blue Cross Blue Shield of Delaware (BCBSD). **(2)** I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete. **(3)** I authorize my employer, as my agent, if applicable to collect premiums by payroll deduction, for remittance to BCBSD, with the understanding that payment will not be complete until actually received by BCBSD. **(4)** Any physician, hospital or other health care provider shall release to BCBSD or its designee any of my and my covered dependents' protected health information for the purpose of payment, health care plan operations, or as otherwise required by law.

Signature of Applicant: **Date:**