

Please complete both sides of this form.

Kalamazoo College
2009
Blue Cross Blue Shield Michigan

Enrollment - new Enrollment - change Waive coverage (complete Parts I & IV)
Currently enrolled – no change – certification of spouse/partner eligibility (complete Parts I, II & III)

I. Employee

Name (Last, First, Middle):		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth:
Social Security number:		Date of hire:	Effective date of enrollment or change:
Work status:	Full Time <input type="checkbox"/>	Part Time _____ Hr/Yr <input type="checkbox"/>	COBRA <input type="checkbox"/> Retired < 65 <input type="checkbox"/>
Address:		City:	State: Zip Code:
Home phone:	Current marital status: Married <input type="checkbox"/> Single <input type="checkbox"/>		
Elected plan: 100% PPO Plan <input type="checkbox"/> 90% PPO Plan <input type="checkbox"/> Waive coverage <input type="checkbox"/> (turn to page 2, sign waiver)			
Elected coverage level: Single (employee only) <input type="checkbox"/> Double (employee plus one) <input type="checkbox"/> Family (employee plus two or more) <input type="checkbox"/>			

II. Dependent(s) to be covered

Name	Birth date	Social Security number	Sex	Relationship of child to employee
<u>Spouse:</u>				
<u>Domestic Partner:</u>				
<u>Child:</u>				
<u>Child:</u>				
<u>Child:</u>				
<u>Child:</u>				
<u>Child:</u>				

Please turn to page 2, complete and sign Election of Group Coverage

For employer use

Open enrollment New hire Other _____

Group Number: 46063 Suffix: 001 (100% Plan) 002 (90% Plan)

Group representative's signature _____ Date _____

III. Election of Group Coverage – complete only if you are enrolling in Group Coverage

1. If you have a spouse or domestic partner, is he/she employed? Yes No

If yes, please indicate spouse/partner's employer's name _____

Does spouse/partner have group coverage available through his/her employer? Yes No

If yes, does that employer pay at least 50% of the cost of the coverage? Yes No

Is your spouse/partner enrolled in that coverage? Yes No

2. Do you - or other dependent(s) including a spouse/partner - maintain other health coverage? Yes No

Covered person _____ Group _____ Policy# _____ Carrier _____ Location _____

Covered person _____ Group _____ Policy# _____ Carrier _____ Location _____

Covered person _____ Group _____ Policy# _____ Carrier _____ Location _____

3. Are you - or your spouse/partner or any other dependent(s) listed in Section II -- enrolled in Medicare? Yes No

If yes, attach a copy of Medicare card(s) and indicate if Medicare enrollee is

Actively working Retired Under 65 ESRD (End Stage Renal Disease)

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations or misstatements about medical coverage could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance subject to the time limit on certain defense provision set forth in the Plan.

Authorization to obtain and disclose information in connection with eligibility for Group Insurance

I understand that in order for my dependents and me to receive health plan benefits, the Plan and its representatives, including, but not limited to, the Plan Administrator and the Claim Administrator, will receive, create, and disclose health information about my dependents and me. I consent to the use and disclosure of this health information for purposes of health care treatment, health care payment, and operations of the Plan and health care providers. I also consent to the use and disclosure of this health information for any other purpose permitted by law. I authorize any adult member of my family to inquire about benefits on my behalf. I know that I have a right to ask for and receive a copy of this authorization.

Print employee name: _____

Employee signature: _____ Date: _____

IV. Waiver of Group Coverage - complete only if you are declining coverage

SPECIAL ENROLLMENT RIGHT #1: If you initially decline this Plan's coverage for yourself or any of your dependents (including your spouse) because of other group health coverage, you may in the future be able to enroll yourself and your dependents in this Plan if application, along with written verification of termination of benefits, is made within 30 days after that other coverage ends for a qualifying reason.

SPECIAL ENROLLMENT RIGHT #2: If you initially decline this Plan's coverage for yourself or any of your dependents (including your spouse) and you later acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this Plan if application is made within 30 days after the marriage, birth, adoption, or placement for adoption.

Print employee name: _____

Employee signature: _____ Date: _____