



**Section A: Employer Information** Please type or print clearly in black or blue ink

1. Employer:					2. Group No:	
3. Effective Date of coverage:	4. Location No:	5. Date of Hire:	6. Job Title:	7. Soc Sec#		

**Section B: Employee Information** (Note: If additional space is needed, please print on separate sheet, sign and date)

8. Last Name:		First:			M.I.	
9. Date of Birth (MM/DD/YYYY):		10. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated			11. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
12. Mailing Address:			13. Apt #:	14. City:	15. State	16. Zip:
17. County:		18. Home Phone with Area Code:		19. Cell Phone:		

**Section C: Coverage Level and Plan Information**

20. Employee Health Coverage Level: (Check box that applies) <input type="checkbox"/> Employee Only <input type="checkbox"/> Family		21. <b>EMPLOYEE PLAN CHOICES:</b> <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan I			HSA Plans	<input type="checkbox"/> Plan G <input type="checkbox"/> Plan H	
22. Physician Health Coverage Level: (Check box that applies) <input type="checkbox"/> Employee Only <input type="checkbox"/> Family		23. <b>PHYSICIAN (OWNER/PARTNER) PLAN CHOICES:</b> <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E				HSA Plans	<input type="checkbox"/> Plan F <input type="checkbox"/> Plan K
24. <input type="checkbox"/> I am refusing all Health Coverage at this time. I understand that if I decide to apply later, coverage may not be available until any qualified special enrollment period. Signature: _____ Date: _____							

**Section D: Health Insurance Dependent Information** Attach separate sheet if additional space is needed for dependent information, sign & date.

25. Last Name: (if different than employee) First, Name, M.I.	Social Security Number	Date of Birth	Relation to You			M/F Sex	Check if Disabled	You Support	Lives with You	Is a Student
			(S) Spouse	(C) Child	(O)* Other					
							<input type="checkbox"/>			
							<input type="checkbox"/>			
							<input type="checkbox"/>			
							<input type="checkbox"/>			
							<input type="checkbox"/>			

\*If you indicated "O" in "Relation to You" above for any dependents, please explain here:

**Section E: Other Health Insurance Information**

26. In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins?  
 Yes  No BCBSF Contract # \_\_\_\_\_ Medicare# \_\_\_\_\_ Pharmacy/Medicare ID# \_\_\_\_\_

**Section F: Acceptance of Health Coverage**

27. **Request for Signature and Certification:** I have read and understand the "limitations and Exclusions" on the reverse side of this enrollment form. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change. I agree to be bound to the terms and conditions of the master policy.

28. Signature:	29. Date:
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