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: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated	11. Gender: ☐Female ☐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) ☐Employee Only ☐Family	21. **EMPLOYEE PLAN CHOICES:** ☐Plan B ☐Plan C ☐Plan I	HSA Plans	☐Plan G ☐Plan H
22. Physician Health Coverage Level: (Check box that applies) ☐Employee Only ☐Family	23. **PHYSICIAN (OWNER/PARTNER) PLAN CHOICES:** ☐Plan D ☐Plan E	HSA Plans	☐Plan F ☐Plan K

24. ☐ 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: (S) Spouse	(C) Child	(O)* Other	M/F Sex	Check if Disabled	You Support	Lives with You	Is a Student
							☐			
							☐			
							☐			
							☐			
							☐			

***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: