



MEMBERSHIP APPLICATION – SCDA Member Benefits Group

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, An independent licensee of the Blue Cross and Blue Shield Association

1. Please indicate reason for Application: **New Subscriber(s)** **Coverage Change** **Cancel** **Miscellaneous**
 COBRA: 18-mo. 29-mo. 36-mo. (Block 19 must be completed.) Left Employment Deceased Name Change
 Firm ID# Change Beneficiary Change Address Change Social Security Number Change From _____
 ID Card Request Add Dependents Return From Layoff/Medical Leave State Continuation Other _____

2. EFFECTIVE DATE OF ACTION REQUESTED: MONTH _____ DAY _____ YEAR _____ **DATE OF HIRE:** MONTH _____ DAY _____ YEAR _____

3. Type Contract: Preferred Blue HSA

IDENTIFICATION

4. Employee — Last Name _____ **First** _____ **Initial** _____ **Home Telephone No.** _____ **Work Telephone No.** _____

5. Mailing Address (Street or P.O. Box) _____ **(City)** _____ **(State)** _____ **(ZIP Code)** _____ **6. Social Security No.** _____

7. Name of Employer/Firm _____ **8. Firm ID #** _____ **9. Blue Cross Group Number**

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10. Deductible Plan _____

REASON FOR COVERAGE CHANGE

11. Check appropriate reason; give occurrence date in Block 13:
A Birth or Adoption C Divorce F Attained Reduction Age
B Death (Name: _____) D Marriage
E Other – Explain: _____

12. Name of spouse to be excluded from coverage if applicable _____ **13. Occurrence Date or Left Employment Date** Mo. _____ Day _____ Yr. _____

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired.

<p>a. HEALTH</p> <p>S – Single <input type="checkbox"/></p> <p>F – Family <input type="checkbox"/></p> <p>F – Employee/Children <input type="checkbox"/></p> <p>8 – Employee/Spouse <input type="checkbox"/></p>	<p>b. REFUSAL OF HEALTH COVERAGE</p> <p>01 <input type="checkbox"/> Other insurance with BCBS of SC</p> <p>02 <input type="checkbox"/> Insurance with another company</p> <p>03 <input type="checkbox"/> US military coverage</p> <p>04 <input type="checkbox"/> Federally qualified HMO</p> <p>07 <input type="checkbox"/> My spouse's coverage with this group</p> <p>09 <input type="checkbox"/> Other third-party administrator</p>	<p>10 <input type="checkbox"/> Planned Administrators Inc.</p> <p>11 <input type="checkbox"/> Non-federally qualified HMO</p> <p>12 <input type="checkbox"/> Covered by Medicare</p> <p>13 <input type="checkbox"/> Covered by CHAMPUS</p> <p>05 <input type="checkbox"/> Other – Explain: _____</p>
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15. If Sponsored Membership, give Sponsor's Social Security No. _____ **16. Job title or description:** _____

17. Life and AD&D – \$25,000 Full Name (Last Name, First, Init.): _____ Relationship _____
SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION Primary Beneficiary(ies): _____
Contingent Beneficiary(ies): _____

18. List All Family Members Covered or Affected By a Change

Last Name	First	Initial	Sex	Birthdate	Mo.	Day	Yr.
YOURSELF:							
Spouse							
Social Security No.							
Child							
Social Security No.							
Child							
Social Security No.							
Child							
Social Security No.							

OTHER INSURANCE INFORMATION

19. Do you or does any member of your family have other health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? YES NO
If Yes: **MEDICARE A** Effective Date _____ **MEDICARE B** Effective Date _____
A. Family Member's Name _____ and Social Security No. _____
B. Name of Insurance Co. _____ Policy No. _____ Effective Date _____
C. Family Member's Employer _____
D. List Names of Covered Persons 1 _____ 2 _____ 3 _____ 4 _____
E. Please circle each type of service covered by this policy: Hospital, Physician/Medical, Prescription Drugs, Dental, Vision

EMPLOYEE CERTIFICATION

20. Employee Certification – Read back for certification statement. Check box if health statement is attached.
I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.
Date: _____ Signature: _____

EMPLOYEE CERTIFICATION STATEMENT

- I understand that upon acceptance of this application by the insurance company, and so long as I meet the eligibility requirements of the contract with this employer, I will be provided with coverage as specified by the group contract made between my employer and the Corporation. I further understand that I am bound by all elements of the contract with regard to my eligibility for this coverage. I authorize release to the company of my past and future medical records and Medicare Part A and B claims information for claims processing purposes.
- I authorize my employer/group to deduct from my pay and remit the prevailing employee's portion that may be required for the cost of said coverage. I represent that the information on this form is true, correct and complete.
- I understand that as a subscriber I am applying for myself and eligible members of my family for healthcare coverage.
- I may enroll my unmarried children and for purposes of this contract, children are defined as my natural or adopted children or children of my spouse by a previous marriage (required by court order) or children residing with me under a legal guardianship. Such children can be covered to age 19 (23, if full-time students) unless my employer has modified this provision or purchased the available extended dependent coverage.
- I authorize the Corporation to obtain from providers of service and hospitals claims information, medical records, or other information relating to my family members and me which are necessary in the administration of my contract. I authorize and consent that the Corporation may disclose any claims information, medical records or other information to any of the Corporation's contractors or any such other third parties as the Corporation deems appropriate.
- I agree that the Corporation has the right of financial recovery at its own expense from any person or organization responsible for injuries to myself or my covered dependents for benefits paid or cost incurred for treatment of such injury. This includes, but is not limited to any benefits payable under Workers' Compensation laws and uninsured motorists benefits. I further agree to cooperate in all matters to secure this right of subrogation.

South Carolina County Codes

01 Abbeville	08 Berkeley	15 Colleton	22 Georgetown	29 Lancaster	36 Newberry	43 Sumter
02 Aiken	09 Calhoun	16 Darlington	23 Greenville	30 Laurens	37 Oconee	44 Union
03 Allendale	10 Charleston	17 Dillon	24 Greenwood	31 Lee	38 Orangeburg	45 Williamsburg
04 Anderson	11 Cherokee	18 Dorchester	25 Hampton	32 Lexington	39 Pickens	46 York
05 Bamberg	12 Chester	19 Edgefield	26 Horry	33 Marion	40 Richland	99 Out-of-state
06 Barnwell	13 Chesterfield	20 Fairfield	27 Jasper	34 Marlboro	41 Saluda	
07 Beaufort	14 Clarendon	21 Florence	28 Kershaw	35 McCormick	42 Spartanburg	