



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
 Beneficiary Change Address Change Social Security Number Change From _____
 ID Card Request Add Dependents Return From Layoff/Medical Leave 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** _____ - _____ **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 if applicable** _____ Mo. _____ Day _____ Yr. _____

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired.

HEALTH / DENTAL / VISION	01 <input type="checkbox"/> Other insurance with BCBS of SC	10 <input type="checkbox"/> Planned Administrators Inc.
S – Single <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	02 <input type="checkbox"/> Insurance with another company	11 <input type="checkbox"/> Non-federally qualified HMO
F – Family <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	03 <input type="checkbox"/> US military coverage	12 <input type="checkbox"/> Covered by Medicare
F – Employee/Children <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	04 <input type="checkbox"/> Federally qualified HMO	13 <input type="checkbox"/> Covered by CHAMPUS
8 – Employee/Spouse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	07 <input type="checkbox"/> My spouse's coverage with this group	05 <input type="checkbox"/> Other – Explain: _____
	09 <input type="checkbox"/> Other third-party administrator	

15. Email Address (Required) _____ **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 – I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.
 Date: _____ Signature: _____