



**Blue Cross Blue Shield
of Oklahoma**

www.bcbsok.com



Return this completed form to:
Blue Cross and Blue Shield of Oklahoma
Attn: Enrollment Services
P.O. Box 3283
Tulsa, OK 74102-3283

FOR OFFICE USE ONLY

MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE
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TELL US WHO YOU WANT TO ENROLL FOR HEALTH BENEFITS COVERAGE:

(select one)

- EMPLOYEE ONLY**
Please complete, read and sign items **1** through **7** and **10** through **12**.
- EMPLOYEE AND SPOUSE**
Please complete, read and sign items **1** through **8** and **10** through **12**.
- EMPLOYEE AND UNMARRIED CHILDREN**
Please complete, read and sign items **1** through **7** and **9** through **12**.
- EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN**
Please complete, read and sign items **1** through **12**.

TELL US WHAT TYPE COVERAGE YOU CHOOSE: (select one)

- 1** **BLUELINCS HMO** **BLUEPREFERRED®** **BLUECHOICE®** **BLUETRADITIONAL®** **BLUEOPTIONS®** **HSA BLUE**

TELL US ABOUT YOURSELF: (please print clearly in ink or type)

2 LAST NAME OF APPLICANT (EMPLOYEE)	FIRST	MIDDLE	RESIDENCE PHONE (INCLUDING AREA CODE) ()
3 ADDRESS (STREET OR P.O. BOX, CITY, STATE)			9-DIGIT ZIP CODE -
4 SOCIAL SECURITY NUMBER -	DATE OF BIRTH (MM/DD/YYYY) / /	SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
5 I AM EMPLOYED BY (COMPANY, CITY, STATE)	HOW MANY HOURS PER WEEK DO YOU WORK?	DATE EMPLOYED FULL TIME (MM/DD/YYYY) / /	EMPLOYER GROUP NO. (TO BE COMPLETED BY EMPLOYER FOR SUBSEQUENT HIRES)
6 DOES ANYONE LISTED ON THIS APPLICATION HAVE HEALTH INSURANCE, MEDICARE OR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS ANYONE LISTED ON THIS APPLICATION LOST COVERAGE DURING THE LAST TWO MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE PROVIDE THE INSURANCE COMPANY NAME	
INSURED'S NAME	MEMBER ID / SUBSCRIBER NO. / CASE NO.	GROUP NO. / POLICY NO.	PERSONS COVERED <input type="checkbox"/> APPLICANT <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT(S) LISTED ON APPLICATION <input type="checkbox"/> OTHER
HAS COVERAGE TERMINATED? <input type="checkbox"/> YES, ON / / <input type="checkbox"/> NO	IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED? <input type="checkbox"/> YES, CURRENT COVERAGE WILL BE TERMINATED <input type="checkbox"/> NO, I WILL KEEP BOTH COVERAGES	NOTE: IF MORE THAN (1) ONE INSURANCE POLICY, PLEASE PROVIDE THE INFORMATION ON ITEM 6 FOR ADDITIONAL INSURANCE CARRIERS ON A SEPARATE SHEET AND ATTACH IT TO THIS APPLICATION.	

IF YOU HAVE SELECTED BLUELINCS HMO, THE FOLLOWING INFORMATION IS REQUIRED:

7 EMPLOYEE'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME)	IS THIS YOUR CURRENT PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP NUMBER FROM PROVIDER DIRECTORY P C P -
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TELL US ABOUT FAMILY MEMBERS APPLYING FOR COVERAGE:

If applying for BlueLincs HMO or BluePreferred with PCP, the primary care physician's name must be provided for your spouse/dependent(s).

8 LAST NAME OF SPOUSE	FIRST	MIDDLE	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER -	MARRIAGE DATE / /
SPOUSE EMPLOYED BY (COMPANY, CITY, STATE)		HOW MANY HOURS PER WEEK DOES SPOUSE WORK?	DATE EMPLOYED FULL TIME (MM/DD/YYYY) / /	BUSINESS PHONE (INCLUDING AREA CODE) ()	
SPOUSE'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME)		IS THIS YOUR SPOUSE'S CURRENT PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		PCP NUMBER FROM PROVIDER DIRECTORY P C P -	

PLEASE CONTINUE WITH DEPENDENT SECTION 9 ON NEXT PAGE

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GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVA CODE	W/C EFF. DATE	W/C EXP. DATE	PROD. CODE	DIVISION CODE	CROSS REFERENCE AGREEMENT NO.
COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	SUB CHAR	DEP CHAR	MINOR CHAR	SUB DENT CHAR	DEP DENT CHAR
LOB	LOB	LOB	LOB	LOB	LOB	LOB	SPECIAL NOTES	CODED BY

9	DEPENDENT'S LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER OTHER (DESCRIBE):	SOCIAL SECURITY NUMBER
	DATE OF BIRTH / /	DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME)		IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP NUMBER FROM PROVIDER DIRECTORY P C P -
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE		IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

9	DEPENDENT'S LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER OTHER (DESCRIBE):	SOCIAL SECURITY NUMBER
	DATE OF BIRTH / /	DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME)		IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP NUMBER FROM PROVIDER DIRECTORY P C P -
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE		IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

9	DEPENDENT'S LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER OTHER (DESCRIBE):	SOCIAL SECURITY NUMBER
	DATE OF BIRTH / /	DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME)		IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	PCP NUMBER FROM PROVIDER DIRECTORY P C P -
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE		IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PLEASE COMPLETE THIS SECTION FOR ALL DEPENDENTS LISTED ABOVE AND APPLYING FOR COVERAGE THAT ARE OVER AGE 19 AND UNDER AGE 23 AND ARE FULL-TIME STUDENTS AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY

FIRST NAME OF STUDENT	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDER GRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
FIRST NAME OF STUDENT	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDER GRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
FIRST NAME OF STUDENT	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDER GRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED

10 NOTICE: You are considered a Timely Enrollee if your application is received by the Plan within 31 days of your eligibility period (when any group initially enrolls or as a new hire upon completion of a waiting period, if any, as specified in the group contract). If you are declining enrollment for your spouse or your dependent(s) because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependent(s) in this plan provided you request Special enrollment within 31 days after the other coverage ends. Qualifying events for this Special enrollment include termination of employment, reduction of work hours, legal separation, divorce, death, employer contributions toward the other coverage have terminated, or C.O.B.R.A. or state continuation of coverage has been exhausted. If you have a new dependent as a result of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself, your spouse, and your dependent(s), provided you request Special enrollment within 31 days of the event and provide documentation showing the date of the event. If you do not enroll upon the initial offering of this coverage (Timely Enrollee) or do not enroll as a Special Enrollee, you, your spouse and/or your dependent(s) may apply during the Open Enrollment period (31 days prior to your group's renewal date) as a Late Enrollee.

- There is a Preexisting Condition limitation on the coverage available from the Plan (except BlueLincs HMO coverage). A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. A Preexisting Condition will not apply to pregnancy or to a newborn or adopted child under age 18, provided the child becomes covered under the Contract/Agreement within 31 days of birth or adoption. The length of the Preexisting Condition limitation period is 12 months after the enrollment date for Timely and Special Enrollees, and 18 months for Late Enrollees. The Preexisting Condition limitation waiting period may be reduced by the number of days you (and/or your spouse, and/or dependents) were covered under a prior health insurance plan(s) should there be no more than a 63-day break in coverage, excluding your waiting period, if any. To do this you may request a Certificate of Coverage form from the prior health plan(s) or issuer and send it to our Enrollment Services department. After the amount of prior creditable coverage has been determined, we will notify you of Preexisting Condition credit based on your prior coverage. Please attach your Certificate of Coverage, if you currently have one.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

AGREEMENTS AND SIGNATURES

11 I, on behalf of myself and any persons whose names appear on this application, hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma or BlueLincs HMO (herein called the "Plan") as stated in this application. I agree that if my application is accepted, coverage will be effective on the effective date assigned by the Plan. I further agree that any changes in my coverage will not become effective until approved by the Plan. I understand that this is an application only, and I should not cancel any existing coverage until I am notified of acceptance, in writing, by the Plan.

- I have read all the statements and notices on this application and represent that those items are true and complete to the best of my knowledge and belief. I know that any material misstatements or omissions of information that are made on this application may be the basis for later withdrawal of insurance coverage or denial of a loss incurred during my or my dependent's coverage. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204, of the Oklahoma State Statutes.

- I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the Plan.
- I understand that if my application is being handled through a broker or agent, I authorize that broker or agent to receive and review my application, which may contain medical information about me or other family members listed on this application.

12	SIGNATURE OF APPLICANT (EMPLOYEE). I AGREE TO ALL THE TERMS OF THIS APPLICATION	DATE SIGNED	SIGNATURE OF SPOUSE I AGREE TO ALL THE TERMS OF THIS APPLICATION	DATE SIGNED
	X	/ /	X	/ /



For office use only.
Divider code: _____

Certification of Enrollment Eligibility Oklahoma Society of Certified Public Accountants Group Health Benefits Plan

This document is to certify that you are eligible to enroll in the association plan in accordance with the terms set forth in the Group Benefits Master Agreement. Namely that you are an active member of the Oklahoma Society of Certified Public Accountants or that you are an employee of a member firm working 30 or more hours per week and a full time resident of the State of Oklahoma.

Please sign and date, and return this form to **Beale Professional Services PO Box 60809. OKC. 73146.**

Section 1. Individual OSCPAs Members – please complete if applying for individual coverage.

Deductible Amount				
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$2500	<input type="checkbox"/> \$1500 HSA	<input type="checkbox"/> \$3000 HSA
Name: _____				
Address: _____				
Phone: _____		Fax: _____		E-mail: _____
OSCPA Membership Date: _____				

Section 2. Member OSCPAs Firms – please complete if applying for employer group coverage.

Deductible Amount (you may select only one.)				
<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$2500	<input type="checkbox"/> \$1500 HSA	<input type="checkbox"/> \$3000 HSA
Name of firm: _____				
Address: _____				
Phone: _____		Fax: _____		Email: _____
Group Contact: _____				
1. Number of employees: _____				
2. Number of employees with other group health coverage: _____				
3. Number of employees who have not met their 30 day waiting period: _____				
4. Number of employees enrolling: _____				
5. Amount of Employers contribution for each employee: _____ %				
(Minimum of 50%)				

Signature: _____ Date: _____