BlueCross BlueShield of Alabama

APPLICATION FOR ENROLLMENT

For Groups with 51 or more Employees and Binding Arbitration

The person completing this application should keep the copy labeled "Employee Copy" and carefully read the information on the reverse side regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Women's Health and Cancer Rights Act Notice.

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001

ENR-431 (Rev. 5-2009)

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)
* INDICATES REQUIRED FIELDS

Application For Enrollment

EMPLOYEE INFORMATION

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GROUP NO.* HEALTH DIV. NO.* DENTAL GROUP NO.* DENTAL DIV. NO.*

LAST NAME* FIRST NAME*

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER*

MAILING ADDRESS*

CITY STATE ZIP

PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL E-MAIL ADDRESS (Optional)

( ) -

○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY)* EMPLOYEE NUMBER

MARITAL STATUS (MARK ONE)

○ SINGLE ○ MARRIED
○ DIVORCED ○ WIDOWED

TYPE OF MEDICAL COVERAGE SELECTED*
○ INDIVIDUAL ○ FAMILY ○ OTHER

TYPE OF DENTAL COVERAGE SELECTED*
(only applies if division number is different)
○ INDIVIDUAL ○ FAMILY ○ OTHER

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

LAST NAME* FIRST NAME*

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER*

DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP
○ SPOUSE ○ OTHER______________________________

GENDER
○ MALE ○ FEMALE

LAST NAME FIRST NAME

MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP
○ CHILD ○ OTHER______________________________

GENDER
○ MALE ○ FEMALE

LAST NAME FIRST NAME

MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP
○ CHILD ○ OTHER______________________________

GENDER
○ MALE ○ FEMALE

LAST NAME FIRST NAME

MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

RELATIONSHIP
○ CHILD ○ OTHER______________________________

GENDER
○ MALE ○ FEMALE

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER

RELATIONSHIP

○ CHILD ○ OTHER_____

GENDER

○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY)

EMPLOYEE INFORMATION

LAST NAME *

FIRST NAME *

SOCIAL SECURITY NUMBER *

If any of your dependent children listed above are 19 or over but under your Group Plan's maximum age limit, do you provide over one-half support for each of them?

○ YES ○ NO

If any dependent child is above the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional application documents for completion.

STUDENT EXTENSION CERTIFICATION - If the Group Plan under which you are applying requires student certification, please list any dependent child applying for student extension.

NAME OF CHILD _____ NAME OF SCHOOL _____

NAME OF CHILD _____ NAME OF SCHOOL _____

NATURE OF APPLICATION

○ NEW CONTRACT APPLICATION

CANCEL CONTRACT
- ○ Medical Coverage
- ○ Dental Coverage
- ○ Medical and Dental Coverage

CHANGE CONTRACT
- ○ Name Change
- ○ Address Change
- ○ Type of Coverage Change

ADD/REMOVE DEPENDENT
- ○ Add Spouse
- ○ Add Dependent Child
- ○ Remove Spouse
- ○ Remove Dependent Child_____

REMOVE DEPENDENT DUE TO
- ○ Marriage of Child under 19
- ○ Entered Military Service
- ○ Divorce
- ○ Death
- ○ Request

QUALIFYING EVENT TYPE:
- ○ Marriage ○ Birth/Adoption
- ○ Loss of Coverage (Attach Certificate of Creditable Coverage)
- ○ Other_____

DATE EVENT OCCURRED

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information.

NAME OF CONTRACT HOLDER/DEPENDENT

POLICY, ID, CONTRACT OR CERTIFICATE NUMBER

NAME OF INSURANCE COMPANY

TYPE COVERAGE

○ INDIVIDUAL ○ FAMILY

EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY)

EMPLOYER'S NAME

GROUP NUMBER

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please give the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

○ PART A (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART B (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART D (MM/DD/YYYY EFFECTIVE DATE) / /

TO BE COMPLETED BY EMPLOYEE

○ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

○ I am requesting cancellation of my existing benefits as checked above.

○ I apply for the Group Health Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, I am a late enrollee and will be required to serve an 18 month exclusion period (unless otherwise stated by your plan) for pre-existing conditions.

THE GROUP PLAN UNDER WHICH YOU ARE APPLYING FOR COVERAGE INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT OTHER THAN A CLAIM FOR BENEFITS UNDER SECTION 502(a) OF ERISA WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE GROUP PLAN.

PLEASE PRINT USING UPPERCASE LETTERS

LAST NAME*

FIRST NAME*

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER* – –

SIGNATURE OF EMPLOYEE*

DATE SIGNED (MM/DD/YYYY) / /

FULL-TIME EMPLOYMENT (MM/DD/YYYY)* / /

TO BE COMPLETED BY EMPLOYER

PRINTED GROUP ADMINISTRATOR NAME

( ) –

EMPLOYER'S PHONE NUMBER

GROUP ADMINISTRATOR SIGNATURE*

DATE SIGNED (MM/DD/YYYY) / /

EMPLOYER'S EXTENSION

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

IMPORTANT DISCLOSURE NOTICE

Notice of Group Health Plan Special Enrollment Rights

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

Notice of Group Health Plan Pre-existing Conditions Exclusion

This group health plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before enrolling in this plan, you might have to wait a certain period of time before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before the day coverage becomes effective. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this pre-existing condition exclusion period by the number of days of your prior "creditable coverage" so long as you have not had a break in coverage of at least 63 days. Most prior health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, U.S. Military, TRICARE, State Children's Health Insurance Program (SCHIP), Federal Employee Program, Peace Corps Service, a state high risk pool, or a public health plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country. You may request a certificate of creditable coverage from a prior plan or issuer. There are also other ways that you can show you have creditable coverage.

To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should attach a copy of any certificates of creditable coverage or other documentation you have to this enrollment application. If you do not have a certificate of creditable coverage, but you do have prior health coverage, Blue Cross and Blue Shield of Alabama will help you obtain one from your prior plan or issuer, if necessary.

All questions about pre-existing condition exclusions and creditable coverage should be directed to your employer at the telephone number and address listed for your employer in this enrollment application.

Even if you have no pre-existing conditions, benefits may not be available under other provisions of the plan. For example, the services may be excluded or may require preapproval. Be sure to read your Summary Plan Description for details.

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was preformed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.