MBWWA Group Insurance

NEW SUBSCRIBER ENROLLMENT FORM

GROUP No. 71502

COMPANY NAME

DIVISION/DEPARTMENT NO.

EFF. DATE	MEDICAL	DENTAL	VISION	STD	STD $$	LTD	LIFE	DEPL	SUPL

Section	Pkg. Code	Billing	BCBSM	VSP	NOTICE	FOR INSURANCE USE ONLY

Status: Single ☐ Married ☐ Divorced ☐ Gender: M ☐ F ☐

Date of Birth ___/___/_____

Date of Marriage ___/___/_____

Employee Social Security No. ___/___/_____ Employee Last Name _____ Employee First Name _____ M.I. ___

Home Street Address _____ City _____ State ___ Zip _____

Phone No. Work _____ Home _____ Ext. ___

☐ I WISH to DECLINE (waive) benefits as I have ALTERNATIVE (other) insurance: I understand the benefits offered under this Plan, but DECLINE coverage for the benefit (s) indicated on the waiver form.
I AM declining coverage: ☐ for myself ☐ for myself and my dependents ☐ for my dependents only. You must complete a separate Waiver Form & provide proof of alternative Medical coverage.

IS DEPENDENT COVERAGE DESIRED? NO ☐ I have no dependents or wish to decline coverage (see above) YES ☐ List all persons to be covered:

Relationship documentation required (marriage license[1], birth certificate[2], court orter[3], physicians statement[4], Copy of Medicare card[5])

First Name (Last name if different from employee)	M.I.	Gender	Date of Birth	Social Security No.	Relationship Code (see chart)
Spouse		☐ M ☐ F			
Dep. 1		☐ M ☐ F			
Dep. 2		☐ M ☐ F			
Dep. 3		☐ M ☐ F			
Dep. 4		☐ M ☐ F			
Dep. 5		☐ M ☐ F			

Relationship Chart (below)	
SP, CH	Spouse[1], Child[2]
SC, LG	Step Child[2], Guardianship[3]
AD	Adoption in Process[3]
DC	Disabled child[4]
QM	Court Ordered Coverage[3]
M	Medicare[5]

If the permanent address of spouse or dependent (s) is different from above please complete information below:

Full name	Street Address	City	State	Zip

Are you or any dependents listed covered by Medicare? ☐ No ☐ Yes If Yes, check reason: ☐ Working Aged ☐ Retired ☐ Disabled ☐ ESRD

Please provide a copy of your Medicare card

Name _____

Medicare Part A effective date ___/___/_____

Medicare Part B effective date ___/___/_____

Medicare Part D effective date ___/___/_____

Authorization for coverage (Signature required) I herby apply for all coverage under my employer's group plan that I have not declined on the waiver form. I am aware that any declined coverage will be subject to restriction upon subsequent application. I understand that I must satisfy the eligibility requirements at my employer's usual place of business on the date coverage for myself and my eligible dependents (if any) becomes effective. By my signature below, I authorize the required payroll deduction for contributory benefits, if any, and represent that all information shown on this application is correct.

Dated _____ Employee's signature in ink _____ Email address _____

TO BE COMPLETED BY THE EMPLOYER

Check all that apply: ☐ Non Union ☐ Union ☐ Full Time ☐ Part Time ☐ New ☐ Rehire ☐ Transfer ☐ Return from layoff ☐ Loss of coverage ☐ Retiree

Date of Hire: _____

Employee Job Title: _____

Effective Date: _____

Annual Wages: _____

EMPLOYEE MUST FULLY COMPLETE THE ENROLLMENT FORM AND SIGN ON THE REVERSE SIDE

Important information regarding your Special Enrollment Rights for Medical Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or 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 "31 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent (s). Failing to accurately submit this information for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person (s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "31 days" after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a State Children's Health Insurance Program (SCHIP) coverage and you request enrollment within "60 days" after that coverage ends; or

- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a SCHIP program with respect to coverage under this plan and you request enrollment within "60 days" after the determination of eligibility for such assistance.

I have read and understand the information provided regarding my Special Enrollment Rights

_____ _____

Date **Employee's Signature**

If your benefits include <u>Life Insurance</u> please complete the following:

LIFE INSURANCE BENEFICIARY DESIGNATION-Please refer to the Instruction page accompanying this form for important information regarding beneficiary designation

Name a primary and contingent beneficiary. If the beneficiary is not related by blood or marriage then indicate **"Not Related".** If you name more than one beneficiary please show the percentage applied to each beneficiary (50% M. Jones, 50% T. Smith etc.)

	Beneficiary Full Name	Address	Social Security No.	Benefit %	Relationship	Date of Birth
PRIMARY BENEFICIARY						
PRIMARY BENEFICIARY						
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						
CONTINGENT BENEFICIARY						

<u>Coordination of Medical Benefits</u>

Do you, your spouse or dependents maintain other health coverage ☐ **Yes** ☐ **No**

If you checked **<u>NO</u>**, you must complete the Coordination of Benefits Information form Part 1 only. If you checked **<u>YES</u>**, you must complete part 2 and/or 3 of the Coordination of Benefits Information form.

New Employee (Subscriber) Enrollment Form Instructions

Please read the following information before completing the attached New Subscriber Enrollment Form
The information on this form and the following conditions are part of your contract with the MBWWA Employee Benefit Trust, Blue Cross Blue Shield of Michigan, VSP and The Hartford for the applicable coverage requested.
I am applying for coverage for myself and my family members identified on this application under my employer's or association's contract with the above listed carriers. Coverage begins on the date determined by my employer's eligibility policies. I and covered members of my family are bound by the terms of the policy and this application.
I understand that the submission of false or misleading information or the omission of material information on the enrollment form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage initially and whenever requested by MBWWA Employee Benefit Trust. (Marriage license, birth certificate, physicians statement, divorce decrees, court order, copy of Medicare card, etc.)

Authorization: I appoint my employer or association to handle all matters of coverage. It may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my employer or association of changes in my status or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM and for other purposes necessary for the carriers to fulfill their contractual and statutory obligations.

Release of information: I acknowledge that the MBWWA Employee Benefit Trust requires me to provide my Social Security number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to the MBWWA Employee Benefit Trust for purposes of administering our coverage. Upon my request, MBWWA Employee Benefit Trust will tell me where the information was sent.

COBRA: I will not be eligible for a waiver of any preexisting exclusion in BCBSM non-employer coverage if I do not elect and exhaust any COBRA coverage available to me.

Employee Instructions

Employee Information (the pink shaded section is for insurance company use)
Enter Social Security number (required), employee's last name, first name and middle initial. Indicate whether single, married, or divorced, male or female. Enter employee date of birth and date of marriage (if applicable). Enter home address beginning with street address, city, state and ZIP code. Enter primary and secondary phone number.

Declining Coverage (gray area)
If you or your dependents have alternative medical coverage through your spouse or some other source, you may elect to decline the coverage offered by your employer.
You must complete a separate Waiver Form and indicate your intention to decline benefits on this Enrollment form. Please indicate whether you wish to decline coverage for yourself only, just your dependents, or you and your entire family.

Dependent Coverage
List all persons to be enrolled. Enter names on appropriate line - Spouse, Dependent 1, 2, 3 and 4 as applicable. Complete additional forms if your all your dependents do not fit on this form. Indicate gender, social security number (required) and the relationship code (codes listed next).
Relationship codes:
SP - Spouse (attach marriage license) **CH - Child** (attach birth certificate) **SC- Stepchild** (attach birth certificate) **LG - Legal guardianship** (attach court order)
QM - Court order coverage (QMCSO) (attach court order) **AD - Child adoption in process** (attach court order) **DC - Disabled child** (attach physicians statement)
M - Medicare (supply copy of Medicare card)
Enter the spouse's or dependent's permanent address if different from the address indicated above.

Medicare status: Indicate if any members listed are enrolled in Medicare. If Yes, check the category under which the member is enrolled in Medicare and enter effective date of the Medicare Parts A, B and D coverage. Please attach a copy of the Medicare card.

Employer Instructions (yellow shaded areas)

Enter employer name and department/division number on the lines designated at the **TOP** of the Enrollment form. Check type of enrollment (union, non-union, new, rehire, etc.). Enter the employee's date of hire and effective date of coverage along with the employee's job title. Include annual wages if the employee is covered for disability benefits (short term or long term). **Please review the employee portion carefully for errors or omissions.**