



ASC Group Health Enrollment Application

Requested Effective Date (subject to BCI approval) _____

Group Number _____

PPO Traditional Managed Care

Please complete each section of this application in ink.

Applicant Information (Employee)					
Your Name (first, initial, last)		Blue Cross ID No. (if currently enrolled)	Social Security No. / /	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City, State, Zip Code		Phone Number ()	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Full-time Hire Date / /	Name of Employer		Job Title	Email Address
For Managed Care Plans Only			Name of Primary Care Physician (PCP)	Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use Only PCP

Dependent Information						
List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).						
Dependent's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight	For Managed Care Plans Only Name of Primary Care Physician (PCP) <small>(For the highest benefit level you must select a PCP)</small> <input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Name (first, initial, last)	/ /		/ /			Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No Office Use Only PCP
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you or any of your family members have other medical and/or dental coverage? YES NO

Coordinating your insurance benefits could reduce the amount you owe a provider.

Current/Prior Coverage (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below. Use extra paper if necessary).

If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a **Certificate of Creditable Coverage** from your prior carrier or other appropriate documents to establish prior creditable coverage. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is primary (**please use additional paper if needed**).

To reduce the 12-month exclusion period by your creditable coverage, you should give your carrier a copy of any **Certificates of Creditable Coverage** you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage.

Other Carrier Information: Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	Type of Coverage	Will this coverage continue?	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please read the reverse side and sign and date this application.

OVER

Location Code _____

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

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Auditor _____

