South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Companion Life

Companion Life is a separate company that does not offer BlueCross BlueShield of South Carolina products. These products are offered by Companion Life, not BlueCross BlueShield of South Carolina. BlueCross BlueShield of South Carolina has no responsibility for these products.

MEMBERSHIP APPLICATION

SM Service Mark of the Blue Cross and Blue Shield Association

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI):_____ 2. Birthdate:☐☐/☐☐/☐☐ 3. Male ☐ Female ☐
4. Address: (Street)_____ (City)_____ (State)_____ (Zip)_____
5. Employee Social Security Number: ☐☐☐-☐☐-☐☐☐☐ 6. Phone: (☐☐☐)☐☐☐-☐☐☐☐
7. Email (Required):_____ 8. Name of Employer:_____
9. Group.: ☐☐-☐☐☐☐☐-☐☐ 10. Dept. No.:_____ 11. Effective Date of Action Requested: ☐☐/☐☐/☐☐
12. GO PAPERLESS: Would you like to receive your Explanation of Benefits electronically? ☐ Yes ☐ No
13. Tobacco Use* ☐ Yes ☐ No

REASON FOR APPLICATION

14. ☐ New Member – Full-time employee working an average of 30 hours per week? ☐ Yes ☐ No Full-time Date of Hire: ☐☐/☐☐/☐☐
☐ Coverage Change – Reason for Change:_____ Date of Occurrence:☐☐/☐☐/☐☐
☐ Cancellation – Date Left Employment: ☐☐/☐☐/☐☐
☐ Reinstatement – Reason: ☐ Return from Layoff ☐ Return from Leave
☐ COBRA Qualifying Event:_____ Start Date: ☐☐/☐☐/☐☐
☐ State Continuation – Start Date: ☐☐/☐☐/☐☐
☐ Sponsored Membership – Sponsored Member's Social Security Number: ☐☐☐-☐☐-☐☐☐☐

COVERAGE INFORMATION

Plan Offered by Employer:_____

15. MEDICAL ELECTION

☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Family
☐ No Medical Coverage due to: (Check one)
☐ Other BlueCross BlueShield of SC Coverage (01)
☐ Covered by Military (03)
☐ Insurance with Another Company (02)
☐ Covered by Medicare (12)
☐ Covered by Spouse with this Employer (07)
☐ Other (05) Explain_____

16. DENTAL ELECTION

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren)
☐ Family ☐ No Dental Coverage

17. LIFE COVERAGE (underwritten by Companion Life)

☐ Life Only (No Medical) ☐ Life and AD & D ☐ Dependent Life
☐ STD ☐ LTD
Life Amount: $_____ Life Class:_____ Earnings $_____
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Beneficiary Designation *(All Plans – applicable only if Life Coverage is available and selected)*
Primary: _____ Relationship: _____
Contingent: _____ Relationship: _____

ENROLLMENT INFORMATION (List all individuals to be covered.)

18.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Other Insurance Yes	Other Insurance No	Tobacco Use * Yes	Tobacco Use * No
Spouse						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐

* Please indicate whether any person age 18 or older has used tobacco four or more times a week in the last six months

OTHER COVERAGE INFORMATION

19. If you or any of your family members have other health (including Medicare), dental or drug coverage other than with this employer, what is the name of the insurance company and the Policyholder's ID Number:_____

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*

I authorize release to Blue Cross and Blue Shield of South Carolina (BlueCross) or its representatives all past and future medical records for myself and eligible dependents and other information deemed necessary by BlueCross to review, process or investigate claims. This authorization includes Medicare Parts A and B claims. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated, or claims denied if fraud or intentional misrepresentations of materials facts have been made on this application subject to the Time Limit on Certain Defenses provisions. The statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for up to 12 months.

Signature:_____ Date:_____