



Burke County

BlueCross BlueShield

Enrollment/Application

Employee Information					
First Name		Middle Initial	Last Name		Suffix
Employee Date of Birth mm/dd/yyyy		Employee Social Security Number		Male	Female
Address		PO Box <i>(For Blue Options HAS you must also provide a street address.)</i>	Apt No.	City	State Zip Code
Company Name			Job Title		
Home Phone Number		Work Phone Number		Date of Benefited Employment mm-dd-yyyy	
Medical Plan:		No Medical	Blue Options SM HSA	Blue Options SM (PPO)	
Medical Coverage (if applicable):	Employee Only	Employee/Child(ren)	Employee/Spouse	Employee/Family	
<p>Decline Coverage: I am rejecting Employee Coverage for the following reason (check one):</p> <p>Another plan offered by my employer</p> <p>An individual plan</p> <p>My spouse's group coverage</p> <p>COBRA or State Continuation</p> <p>I and/or my dependents are not covered by any other health benefit plan</p> <p>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 or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.</p> <p>I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.</p>					
Date: _____		Employee Signature: _____			



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Family Information – Complete for anyone taking medical and/or dental coverage*						
Name <i>First, Middle Initial, Last, Suffix</i>	Social Security Number	Date of Birth <i>mm/dd/yyyy</i>	Sex	Health	Dental	Child Status <i>(please check one)</i>
Spouse	<i>Required</i>		M	Y	Y	
		F	N	N		
Child 1			M	Y	Y	Foster Adopted Handicapped** Under the age of 26***
			F	N	N	
Child 2			M	Y	Y	Foster Adopted Handicapped** Under the age of 26***
			F	N	N	
Child 3****			M	Y	Y	Foster Adopted Handicapped** Under the age of 26***
			F	N	N	
<p>* Application does not guarantee enrollment.</p> <p>** A request for coverage (for P24) is required if your child is 26 years or older and will be reviewed to determine eligibility</p> <p>*** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.</p> <p>**** If you have more than three children, complete this section (Section D) on another application.</p>						Additional dependent and/or custodial parent information attached.