Burke County
BlueCross BlueShield
Enrollment/Application

Employee Information

First Name	Middle Initial	Last Name	Suffix

Employee Birthday	Employee Social Security Number	Male ◯	Female ◯

Address	PO Box *(For Blue Options HAS you must also provide a street address.)*	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℠ HSA ◯	Blue Options℠ (PPO) ◯

Medical Coverage (if applicable):	Employee Only ◯	Employee/Child(ren) ◯	Employee/Spouse ◯	Employee/Family ◯

Decline Coverage: I am rejecting Employee Coverage for the following reason (check one):

- ◯ Another plan offered by my employer
- ◯ An individual plan
- ◯ My spouse's group coverage
- ◯ COBRA or State Continuation
- ◯ I and/or my dependents are not covered by any other health benefit plan

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.

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.

Date: _____ **Employee Signature:** _____

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Family Information – Complete for anyone taking medical and/or dental coverage*						
Name *First, Middle Initial, Last, Suffix*	**Social Security Number**	**Birthday** *mm/dd/yyyy*	**Sex**	**Health**	**Dental**	**Child Status** *(please check one)*
Spouse	*Required*		◯ M ◯ F	◯ Y ◯ N	◯ Y ◯ N	
Child 1			◯ M ◯ F	◯ Y ◯ N	◯ Y ◯ N	◯ Foster ◯ Adopted ◯ Handicapped** ◯ Under the age of 26***
Child 2			◯ M ◯ F	◯ Y ◯ N	◯ Y ◯ N	◯ Foster ◯ Adopted ◯ Handicapped** ◯ Under the age of 26***
Child 3****			◯ M ◯ F	◯ Y ◯ N	◯ Y ◯ N	◯ Foster ◯ Adopted ◯ Handicapped** ◯ Under the age of 26***

* Application does not guarantee enrollment.

** A request for coverage (for P24) is required if your child is 26 years or older and will be reviewed to determine eligibility

*** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.

**** If you have more than three children, complete this section (**Section D)** on another application.

◯ Additional dependent and/or custodial parent information attached.