



Blue Cross Blue Shield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

Enrollment Form

PLEASE PRINT ALL INFORMATION

To Be Completed By Human Resources

Group Number	Effective Date	Employee Type: <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired <input type="checkbox"/> Decline (If declining coverage, please complete page 2.)		
Enrollment: <input type="checkbox"/> New Hire <input type="checkbox"/> Open <input type="checkbox"/> Qualifying Event	(check event and give event date; attach copies of legal documents for adoption, custody, guardianship, court order, MDHS, divorce)		<input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Court Order <input type="checkbox"/> Custody/Guardianship	Event Date:
		<input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Group Transfer <input type="checkbox"/> New Hire	<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> MDHS	
Employee Occupation:				

EMPLOYEE	Social Security Number	First Name	M.I.	Last Name:	Phone Number:	
	Mailing/Street Address		Apt./Ste	City	State	Zip Code
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:	Hire Date:	Medical Coverage Type: <input type="checkbox"/> Employee <input type="checkbox"/> Family <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Spouse	Dental Coverage Type: <input type="checkbox"/> Employee <input type="checkbox"/> Family <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Spouse
	CREDITABLE COVERAGE			OTHER INSURANCE INFORMATION		
Did you have prior coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter From and Through dates. From: _____ Through: _____			Are you covered by any other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete "Other Coverage" form.			

DEPENDENTS	FULL NAME	FIRST NAME	RELATIONSHIP TO EMPLOYEE	SEX M/F	DATE OF BIRTH			INDICATE YES OR NO FOR EACH ITEM BELOW			
		LAST NAME			MO	DAY	YEAR	FULL-TIME STUDENT IF AGE 19 - 25	COBRA PARTICIPANT	OTHER HEALTH COVERAGE IF YES, COMPLETE "OTHER COVERAGE" FORM.	CREDITABLE COVERAGE IF YES, PROVIDE FROM AND THROUGH DATES.
										FROM	THROUGH
	Husband/Wife										
	Children										
Name of school for those age 19 and over _____											

For myself and dependent's named above, I apply for health insurance coverage available through my Employer. I represent that all the information provided by me in this Enrollment Form is complete and accurate. I certify that I have read the above statements or that they have been read to me and that they are true and complete to the best of my knowledge. I understand that any misrepresentation of this information on my part may be used by my Employer to reduce or deny a claim for benefits as well as result in disciplinary action. I also agree to pay the appropriate fees for the coverage and authorize my Employer to deduct that amount from my wages and salary. Last, I acknowledge that the health insurance applied for is subject to all exclusions and limitations set forth in the Master Group Contract.

AUTHORIZATION (EMPLOYEE SIGNATURE)	MO.	DATE DAY	YR.
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DECLINATION

Employee Name: _____ Social Security #: _____

Check which coverage declined. Medical Dental Employee ID#: _____

Birth Date: _____

NOTE: You must complete this form if you are waiving (declining) insurance coverage available to you through your Employer.

This is to certify that I have been given the opportunity to apply for group coverage available to me and my dependents pursuant to state law through my Employer. I proclaim that I was not pressured or forced by my Employer into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage, hereafter, that such subsequent applications shall be subject to the applicable terms and conditions of the Master Group Contract.

Date: _____ Employee Signature: _____