AAAS employee benefit fund

AAAS Employee Benefit Fund
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BlueCross BlueShield of Alabama

HEALTH - Application for Enrollment/Changes

INDICATE Employer Company GROUP:			
❍ 97720 AHP-Competitor	❍ 58920 AHP-Value	❍ 97782 AHP-Economy	❍ 77220

Employer Company Name				Employer Phone Number
Employee Name (Last)	(First)	(Initial)		Employee Phone Number
Street Address	City	State	Zip	Employee Date of Birth

CHECK ONE:	CHECK ONE:	Employee Social Security Number	Date of Hire
□ Male □ Female	□ Single □ Divorced □ Married □ Widowed		

LIST ALL ELIGIBLE DEPENDENTS TO ENROLL LAST NAME FIRST NAME INITIAL	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH M	D	Y
1.		□ Husband □ Wife			
2.		□ Son □ Daughter			
3.		□ Son □ Daughter			
4.		□ Son □ Daughter			
5.		□ Son □ Daughter			

NATURE OF APPLICATION – CHOOSE ONE

NEW CONTRACT APPLICATION	CHANGE OF CONTRACT	ADD DEPENDENT	REMOVE DEPENDENT
O New EMPLOYEE ONLY O New EMPLOYEE + SPOUSE *(AHP Only)* O New EMPLOYEE + CHILDREN *(AHP Only)* O New EMPLOYEE + FAMILY	O Name Change O Address Change O Type of Coverage Change FROM: _____ TO: _____	O Add Spouse O Add Dependent Child	O Divorce ___ Remove all dependents ___ Remove spouse only O Death O Loss of Eligibility Reason_____

EVENT AND DATE OCCURRED: (Examples: Marriage, Birth, Divorce, Death) _____

Do you or your dependents currently have coverage with BC/BS of AL? YES NO If yes, list your contract number. _____	Do you or your dependents have coverage with another group health plan? YES NO Ins. Co. Name _____ Contract # _____

I apply for the Group Health Benefit Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by the law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for service to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, my next opportunity to enroll would be at open enrollment.

SIGNATURE OF EMPLOYER DATE	SIGNATURE OF EMPLOYEE DATE
EMPLOYER ADDRESS	REQUESTED START DATE

AAASEBF Use Only

Effective Date	Plan	Division #	Contract #	B / A