Empire Blue Cross/Blue Shield

DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

Rev. 2/2012

EMPLOYER USE ONLY

Group Name

Group No. | Employee Code

Effective Date Requested ____/____/____

TRUST USE ONLY

Employee No.	Billing Class	Group Code

SECTION 1

Your Last Name | First | M.I.

Your Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

Address

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Date of Marriage ____/____/____ Date of Divorce ____/____/____

City | State | Zip Code

Phone No.: (____)_____ (____)_____

Employment Status: ☐ Full-time ☐ Part-time ☐ Active ☐ Retired ☐ COBRA

Date of Employment ____/____/____ Date of Retirement ____/____/____

SECTION 2

☐ New Enrollment/Reinstatement (complete Section 4)

☐ Change Coverage to: (check new coverage)

☐ Cancel Coverage: (check those that apply)

☐ Add or Delete Dependent: (complete Section 4)

☐ Change Enrollee's Information: (complete Section 1 with new information)

REASON: _____

Type	Option	Individual	2-Person	Family	Complement to Medicare
Healthy Adv. PPO		☐	☐	☐	☐
EPO-10		☐	☐	☐	☐
EPO-20		☐	☐	☐	☐
A. PPO		☐	☐	☐	☐
HMO		☐	☐	☐	☐
Dental		☐	☐	☐	☐
Vision		☐	☐	☐	☐

Date of change: ____/____/____

SECTION 3

OTHER COVERAGE?

Is there coverage under any other group health plan available to you or any member of your family?

☐ No ☐ Yes

If Yes; Policyholder Name | Relationship ☐ Self ☐ Spouse ☐ Child

Social Security Number | Birthdate ____/____/____

Insurance Co. Name | Policy #

Address

Plan Type ☐ Self Only ☐ Self and Family **Coverage Type** ☐ Health ☐ Drug ☐ Dental ☐ Vision

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

SECTION 4

ADD	DELETE	Relationship	NAME Last First M.I.	Birthdate (mo/day/yr)	Full-Time Student	Social Security #	Medicare A & B Effective Date
☐	☐	**Self** ☐ M ☐ F		____/____/____		_____-_____-_____	____/____/____ ____/____/____
☐	☐	☐ Husband ☐ Wife ☐ Other		____/____/____		_____-_____-_____	____/____/____ ____/____/____
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	_____-_____-_____	____/____/____ ____/____/____
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	_____-_____-_____	____/____/____ ____/____/____
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	_____-_____-_____	____/____/____ ____/____/____
☐	☐	☐ Son ☐ Daughter		____/____/____	☐ Yes ☐ No	_____-_____-_____	____/____/____ ____/____/____

SECT. 5

Do your dependents reside in your home?
☐ Yes ☐ No If No give address:

Do you have a disabled dependent beyond age 19?
☐ No ☐ Yes List name(s):

Full-time college students age 19 and over:
List names | School Name and Address | Expected Graduation:

AGREEMENT: I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Applicant's Signature _____ Date _____

Adult Dependent Signature _____ Date _____

Employer's Signature _____

Date ____/____/____