Empire Blue Cross/Blue Shield – PPO/ALT

DUTCHESS EDUCATIONAL HEALTH INSURANCE CONSORTIUM

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.

Address

City | State | Zip Code

Your Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

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

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

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
Matrix		☐	☐	☐	☐
PPO		☐	☐	☐	☐
A. PPO		☐	☐	☐	☐
HMO		☐	☐	☐	☐
Dental		☐	☐	☐	☐
Vision		☐	☐	☐	☐
Misc.		☐	☐	☐	☐

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

SECTION 4

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS

Copy of medical card required

FOR HMO OR POS ENROLLMENT ONLY

ADD	DELETE	Relationship	NAME Last	First	M.I.	Birthdate (mo/day/yr)	Full-Time Student	Social Security #	Medicare A & B Effective Date	Medical Practice Number	Primary Care Physician – OB/GYN	Existing Patient ✓
☐	☐	Self ☐ M ☐ F				__/__/__		__–__–__	__/__/__ __/__/__		PCP OB/GYN	
☐	☐	☐ Husband ☐ Wife ☐ Other				__/__/__		__–__–__	__/__/__ __/__/__		PCP OB/GYN	
☐	☐	☐ Son ☐ Daughter				__/__/__	☐ Yes ☐ No	__–__–__	__/__/__ __/__/__		PCP OB/GYN	
☐	☐	☐ Son ☐ Daughter				__/__/__	☐ Yes ☐ No	__–__–__	__/__/__ __/__/__		PCP OB/GYN	
☐	☐	☐ Son ☐ Daughter				__/__/__	☐ Yes ☐ No	__–__–__	__/__/__ __/__/__		PCP OB/GYN	
☐	☐	☐ Son ☐ Daughter				__/__/__	☐ Yes ☐ No	__–__–__	__/__/__ __/__/__		PCP OB/GYN	

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 ________

Adult Dependent Signature ____________________ Date ________

Adult Dependent Signature ____________________ Date ________

Employer's Signature ____________________

Date ____/____/____

White Copy – ROSE & KIERNAN, INC. Yellow Copy – PLAN ADMINISTRATOR/INSURER Pink Copy – EMPLOYER Gold Copy – EMPLOYEE

Form 0702