



# Member Application for Active Group Health Coverage



— Please Print —

— See Reverse Side —

1. Employment Information			
Employer/Group Name <b>Washington University</b>	Group No., if known	Date employed (mo/day/yr)	Coverage Effective Date (mo/day/yr)
Title	Department Name		Social Security No.

2. Coverage Information		
<b>Health coverage:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please check the program chosen: <input type="checkbox"/> Alliance Excel <input type="checkbox"/> Alliance Basic <input type="checkbox"/> Choice Excel <input type="checkbox"/> Choice Basic <input type="checkbox"/> Medicare Disability	Also, if YES, please check one coverage type: <input type="checkbox"/> employee only <input type="checkbox"/> emp. & one <input type="checkbox"/> emp. & two or more

3. Applicant and Family Information			
Name: Last	First	Middle	Are you: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> sep. <input type="checkbox"/> div. <input type="checkbox"/> widowed
Address: Street			Home phone no. ( )
City		State	Zip Code
County			
Are you: <input type="checkbox"/> a full-time active employee <input type="checkbox"/> a part-time employee eligible for benefits <input type="checkbox"/> a former full-time employee <input type="checkbox"/> a retiree <input type="checkbox"/> a former covered dependent <input type="checkbox"/> currently off work because of illness or injury		If you checked former employee or former covered dependent, give the date you became eligible for continuation of group coverage (mo/day/yr):	

Please complete below for each eligible family member you want covered, **including yourself**. (Your spouse or your domestic partner, and any unmarried children under the group's dependent age limit, are eligible as dependents.) Attach a second sheet, if necessary.

**\*Important:** In last column, check "yes" only if other group health insurance will remain in effect.

First Name	Middle	Last, if different	Sex M/F	Relationship to Applicant	Date of Birth mo   day   yr	Social Security Number	Totally Disabled	Enrolled in Medicare	Enrolled in Other Group Coverage*
<b>00 Applicant</b>				<b>Self</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
01 Spouse							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
02 Domestic Partner							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
03 Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
04 Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
05 Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
06 Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Note: Failure to complete the following questions may result in claims delays.**

**Disability Information:** If you or any dependents checked YES to being *Totally Disabled*,\* please give date disability began: \_\_\_\_\_

Describe Disability: \_\_\_\_\_

\*A definition of Total Disability is provided on the reverse side of this form.

**Medicare Information:** If you or any dependents checked YES to being *enrolled in Medicare*, please give the following Medicare information and attach copy of Medicare card:

Name: \_\_\_\_\_ Soc. Sec. no.: \_\_\_\_\_ Medicare claim no.: \_\_\_\_\_

Part A / Part B eff. date(s): \_\_\_\_\_ / \_\_\_\_\_ Reason(s) for Medicare eligibility:  Age  Disability  End-stage renal disease

<b>4. Do you have any other coverage with us at this time?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give current identification no.:
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I have read the Application Agreement on the reverse side of this form.

X \_\_\_\_\_  
Applicant's signature

X \_\_\_\_\_  
Date

**Note: Applicant/employee copy may be used as a temporary identification card for 30 days from the effective date authorized by the employer. Providers should verify coverage with Blue Cross and Blue Shield of Missouri before providing care.**

X \_\_\_\_\_  
(Human Resources authorization)

Blue Cross and Blue Shield of Missouri is the name RightCHOICE® Managed Care, Inc. (RIT) uses to do business in most of Missouri. RIT provides administrative services and network access only and does not underwrite benefits. RIT is an independent licensee of the Blue Cross and Blue Shield Association.

**OFFICE USE ONLY:**

Group #	Identification #	Effective Date	Package #	Contract Type

## Application Agreement

(Please read this before signing application.)

**Applicant/Subscriber** (the person completing and signing this form) **understands and agrees to all the items listed below, on behalf of himself/herself and as the authorized representative of his/her spouse or domestic partner and/or any other covered dependents.**

**Requesting coverage:** Unless indicated otherwise in Section 2 on the front of this form, I request the group coverage to which I am entitled, or may become entitled.

I authorize proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this coverage. I understand that I cannot transfer my or my covered dependents' right to receive benefit payment, and I agree to repay promptly any benefit payment to which I or my covered dependents were not entitled.

I certify that the information provided on this form is true and correct and attest to the eligibility of all persons listed.

I understand that my employer and Blue Cross and Blue Shield of Missouri (BCBSMo), rely upon the information provided on this Application in issuing my health coverage. If I omit any information or provide any false or incomplete information, this can result in the cancellation of my health coverage. I agree to repay promptly any benefit payment to which I or my dependents were not entitled.

I understand that completion of this form does not guarantee acceptance of my application for coverage.

### Release of Information:

I will furnish all information required by my employer and BCBSMo. I authorize and direct any provider of care or other entity to release to my employer and to BCBSMo and its parent, affiliates, subsidiaries or designees all information relating to any medical history, diagnosis, prognosis or care provided to me or any of my covered dependents.

My employer and BCBSMo and its parent, affiliates, subsidiaries or designees are authorized to receive and release such information in connection with processing claims, medical management programs or carrying out any other lawful purpose relating to participation in the health benefits plan.

I understand that my employer and BCBSMo will treat my personal health information, and that of my listed family members, as confidential and will not disclose it for purposes other than those listed above or as otherwise permitted by law.

This authorization remains valid unless I expressly revoke the authorization by notifying my employer and BCBSMo in writing. Any such revocation would not apply to actions taken prior to the revocation or to the release of any information required or authorized by law. Also, any such revocation or any refusal to consent to the release of such information to my employer and BCBSMo shall permit the denial of my claims for benefits.

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***Definition of Total Disability:*** A Subscriber or a dependent who had been actively working is considered to have a Total Disability if he or she is not actively working because he or she is unable to perform the material and substantial duties of his or her occupation. A retiree or a dependent who had not been actively working is considered to have a Total Disability if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. In any of these situations, the disability may be either permanent or temporary.

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