MEMBERSHIP APPLICATION

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA, An independent licensee of the Blue Cross and Blue Shield Association
COMPANION HEALTHCARE, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina, An independent licensee of the Blue Cross and Blue Shield Association
COMPANION LIFE INSURANCE COMPANY, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina.

1. Please indicate reason for Application: ☐ **New Subscriber(s)** ☐ **Coverage Change** ☐ **Cancel** ☐ **Miscellaneous**
☐ COBRA: ☐ 18-mo. ☐ 29-mo. ☐ 36-mo. (Block 22 must be completed.) ☐ Life Coverage ☐ Yes ☐ No ☐ Transfer Within Your Group From _____
☐ Left Employment : ☐ No Conversion ☐ Wants Conversion or Medicare Complementary Info ☐ Deceased ☐ Name Change
☐ Department/Payroll Number Change ☐ Address Change ☐ Beneficiary Change ☐ Social Security Number Change From _____
☐ ID Card Request ☐ Add Dependents ☐ Return From Layoff/Medical Leave ☐ Physician Change ☐ Other _____

2. EFFECTIVE DATE OF ACTION REQUESTED: **MONTH** _____ **DAY** _____ **YEAR** _____ **DATE OF HIRE:** **MONTH** _____ **DAY** _____ **YEAR** _____ **ELIGIBILITY DATE:** **MONTH** _____ **DAY** _____ **YEAR** _____

3. Type Contract: ☐ Preferred Blue ☐ Comprehensive ☐ CHOICES ☐ CHC ☐ HSA ☐ HRA

IDENTIFICATION

4. Employee — Last Name | First | Initial | Home Telephone No.

5. Social Security No.

6. Mailing Address (Street or P.O. Box) | (City) | (State) | (Zip Code) | (County Code - see back)

7. Name of Employer

8. Blue Cross Group Number ☐☐ – ☐☐☐☐☐ – ☐☐ – ☐

9. Dept. No.

10. Payroll No.

REASON FOR COVERAGE CHANGE

11. Check appropriate reason; give occurrence date in Block 13:
A ☐ Birth or Adoption
B ☐ Death (Name: _____)
C ☐ Divorce
D ☐ Marriage
E ☐ Other – Explain: _____
F ☐ Attained Reduction Age

12. Name of spouse to be excluded from coverage if applicable

13. Occurrence Date or Left Employment Date Mo. Day Yr.

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired. (Indicate life coverage desired, if applicable, in blocks 15 through 19.)

	a. HEALTH	**b. DENTAL**
S – Single	☐	☐
F – Family	☐	☐
F – Employee/Children	☐	☐
8 – Employee/Spouse	☐	☐

c. REFUSAL OF HEALTH COVERAGE
01 ☐ Other insurance with BCBS of SC
02 ☐ Insurance with another company
03 ☐ US military coverage
04 ☐ Federally qualified HMO
07 ☐ My spouse's coverage with this group
09 ☐ Other third-party administrator
10 ☐ Planned Administrators Inc.
11 ☐ Non-federally qualified HMO
12 ☐ Covered by Medicare
13 ☐ Covered by CHAMPUS
05 ☐ Other – Explain: _____

15. If Sponsored Membership, give Sponsor's Social Security No. _____

16. Types and Amounts of Life Insurance Coverage Desired
☐ Life _____ Supplemental:
☐ AD&D _____ ☐ Life _____
☐ Dep. Life _____ ☐ AD&D _____
☐ STD _____ ☐ Dep. Life _____
☐ LTD _____

17. Earnings $ _____ (Amount) (Check One) ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

18. Life Class

19. Full Name (Last Name, First, Init.): Relationship
Primary Beneficiary(ies): _____
Contingent Beneficiary(ies): _____
SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION

20. Job title or description:

21. List All Family Members Covered or Affected By a Change — **For Contracts That Require Primary Care Physician Selection**

Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.	Primary Care Physician Name	Provider Number	Was This Your Regular Physician? Yes	No
YOURSELF:							Yes	No
Spouse							Yes	No
Social Security No.								
Child							Yes	No
Social Security No.								
Child							Yes	No
Social Security No.								
Child							Yes	No
Social Security No.								

OTHER INSURANCE INFORMATION

22. Do you or does any member of your family have other health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? ☐ YES ☐ NO
If Yes: MEDICARE A ☐ Effective Date _____ MEDICARE B ☐ Effective Date _____
A. Family Member's Name _____ and Social Security No. _____
B. Name of Insurance Co. _____ Policy No. _____ Effective Date _____
C. Family Member's Employer _____
D. List Names of Covered Persons 1 _____ 2 _____ 3 _____ 4 _____
E. Please circle each type of service covered by this policy: Hospital, Physician/Medical, Prescription Drugs, Dental, Vision

EMPLOYEE CERTIFICATION

23. Employee Certification – Read back for certification statement. Check box if health statement is attached. ☐
I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.

Date: _____ Signature: _____

EMPLOYEE CERTIFICATION STATEMENT

I understand that upon acceptance of this application by the insurance company, and so long as I meet the eligibility requirements of the contract with this employer, I will be provided with coverage as specified by the group contract made between my employer and the Corporation. I further understand that I am bound by all elements of the contract with regard to my eligibility for this coverage. I authorize release to the company of my past and future medical records and Medicare Part A and B claims information for claims processing purposes.

If refusing coverage, I understand that if I later wish to enroll in the group plan offered by my employer and I am not with a federally qualified HMO, I must provide satisfactory evidence of insurability.

If enrolling in the HMO, I also agree to the conditions listed below. I also understand that I am required to select a personal physician from the physicians associated with the Corporation for HMO coverage and that I am required to have my physician provide or arrange, in advance, for all the medical services I need except for life-threatening emergencies. I also authorize my employer/group to deduct from my pay and remit the prevailing employee's portion that may be required for the cost of said coverage. I represent that the information on this form is true, correct and complete.

INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).

B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.

C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.

D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.

E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.

For Subscribers That Must Select A Primary Care Physician

THE INFORMATION SUPPLIED ON THE FACE OF THIS FORM AND THE FOLLOWING CONDITIONS FORM PART OF MY CONTRACT WITH THE CORPORATION

- I understand that as a subscriber I am applying for myself and eligible members of my family for healthcare coverage.
- I understand that by enrolling in CHOICES, I am automatically entitled to HMO benefits from Companion HealthCare and medical insurance benefits from Blue Cross and Blue Shield of South Carolina.
- I may enroll my unmarried children residing in the HMO service area. For purposes of this contract children are defined as my natural or adopted children or children of my spouse by a previous marriage (required by court order) or children residing with me under a legal guardianship. Such children can be covered to age 19 (23, if full-time students) unless my employer has modified this provision or purchased the available extended dependent coverage.
- TO BE ENTITLED TO BENEFITS, MY FAMILY AND I AGREE TO SEEK ALL HEALTHCARE SERVICES THROUGH OUR CHOSEN PRIMARY CARE PHYSICIANS OR FROM OTHER PROVIDERS SPECIFICALLY AUTHORIZED IN ADVANCE BY OUR CHOSEN PRIMARY CARE PHYSICIANS WITH THE EXCEPTION OF GENUINE EMERGENCY SERVICES WHEN IT IS NOT POSSIBLE OR PRACTICAL TO CONTACT OUR CHOSEN PRIMARY CARE PHYSICIANS.
- I authorize the Corporation to obtain from providers of service and hospitals claims information, medical records, or other information relating to my family members and me which are necessary in the administration of my contract. I authorize and consent that the Corporation may disclose any claims information, medical records or other information to any of the Corporation's contractors or any such other third parties as the Corporation deems appropriate.
- I agree that the Corporation has the right of financial recovery at its own expense from any person or organization responsible for injuries to myself or my covered dependents for benefits paid or cost incurred for treatment of such injury. This includes, but is not limited to any benefits payable under Workers' Compensation laws and uninsured motorists benefits. I further agree to cooperate in all matters to secure this right of subrogation.

NOTE: YOU MUST SELECT A PRIMARY CARE PHYSICIAN AT THE TIME OF ENROLLMENT.

South Carolina County Codes

01 Abbeville	08 Berkeley	15 Colleton	22 Georgetown	29 Lancaster	36 Newberry	43 Sumter
02 Aiken	09 Calhoun	16 Darlington	23 Greenville	30 Laurens	37 Oconee	44 Union
03 Allendale	10 Charleston	17 Dillon	24 Greenwood	31 Lee	38 Orangeburg	45 Williamsburg
04 Anderson	11 Cherokee	18 Dorchester	25 Hampton	32 Lexington	39 Pickens	46 York
05 Bamberg	12 Chester	19 Edgefield	26 Horry	33 Marion	40 Richland	99 Out-of-state
06 Barnwell	13 Chesterfield	20 Fairfield	27 Jasper	34 Marlboro	41 Saluda	
07 Beaufort	14 Clarendon	21 Florence	28 Kershaw	35 McCormick	42 Spartanburg	