

PLEASE COMPLETE THE ENTIRE APPLICATION EXCEPT FOR THE SHADED AREAS. THESE WILL BE FILLED IN BY YOUR BCBSWI/CCB REPRESENTATIVE.

**Blue Cross Blue Shield of Wisconsin\***

**CompcareBlue<sup>SM</sup>**  
Compcare Health Services  
Insurance Corporation\*

**Dental**

## Employer Information

Requested Effective Date: Medical: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dental: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MEDICAL/Group #: \_\_\_\_\_ Section #: \_\_\_\_\_ DENTAL/Group #: \_\_\_\_\_ Section #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Location of Workplace (city): \_\_\_\_\_

## I. Employee Information

**Employee Instructions:** Please print in black ink. Please fill out the entire application for anyone applying for coverage. Remember, as the **employee** you must be applying for coverage for anyone else in the family to be eligible.

Social Security #: \_\_\_\_\_ Job Title: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

What is the first day you worked **full-time** with your present employer? \_\_\_\_/\_\_\_\_/\_\_\_\_ Hours Worked per Week: \_\_\_\_\_

Are You:

- a.)  Single     Married     Divorced     Widow/Widower
- b.) A Retiree?     Yes     No
- c.) On COBRA or State Continuation?     Yes     No    If YES, start date & reason \_\_\_\_\_  
Termination date \_\_\_\_\_

If you or any of your dependents are entirely waiving coverage, please check the boxes below that apply **and fill out sections I & V.** for those who are waiving.

- Waiving the entire family  
 Waiving the spouse  
 Waiving the dependents

## II. Type of Coverage

Please indicate if you are a:

- |   |  |
|---|--|
| <p><input type="checkbox"/> <b>New Group Enrollee</b></p> <p><input type="checkbox"/> <b>New Hire</b><br/>(You must apply during your probationary period.)</p> <p><input type="checkbox"/> <b>Late Applicant</b><br/>(Some plans do not allow for enrollment as a late applicant. Please check with your employer or with customer service. Late applicants are normally subject to a pre-existing condition limitation period.)</p> <p><input type="checkbox"/> <b>Open Enrollment</b><br/>(Some plans do not allow for open enrollment. Please check with your employer or with customer service.)</p> | <p><input type="checkbox"/> <b>Special Enrollment Period</b></p> <p><input type="checkbox"/> Birth</p> <p><input type="checkbox"/> Adoption/Placement for adoption</p> <p><input type="checkbox"/> Marriage</p> <p><input type="checkbox"/> Termination or exhaustion of other coverage (e.g., divorce, death of a spouse)</p> <p><input type="checkbox"/> Other (Please explain)</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|--|

\*An independent licensee of the Blue Cross and Blue Shield Association.

## II. Type of Coverage (Continued)

Please select the type of coverage you are applying for:

MEDICAL:  Employee Only  Employee & Spouse  Employee & Children  Employee, Spouse & Children

Network Selection: \_\_\_\_\_

DENTAL:  Employee Only  Employee & Spouse  Employee & Children  Employee, Spouse & Children

Please indicate the dental clinic name and number below if you are enrolling in Dentacare.

Dentacare Clinic Name: \_\_\_\_\_ Dentacare Clinic Number: \_\_\_\_\_

## III. Applicant Enrollment Information

Do any family members reside at an address that is different from the employee applying?

Yes (If Yes, please specify below)  No

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Complete the following for all family members, beginning with you the employee, who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

← Complete for POS or HMO only  
(not required for Open Access) →

NAME: Doe Jane B.			Gender/ Student Status	Relationship	Physician/Clinic Name Medical Clinic Number		
Last	First	Middle Initial					
01	<b>EMPLOYEE Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Primary Care Physician: _____		
	Date of Birth: ____/____/____				Clinic Name: _____		
02	<b>SPOUSE Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Primary Care Physician: _____		
	Social Security #: _____ Date of Birth: ____/____/____				Clinic Name: _____		
03	<b>Dependent Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	Primary Care Physician: _____	
	Social Security #: _____ Date of Birth: ____/____/____		Full-time Student: <input type="checkbox"/> Y <input type="checkbox"/> N			Clinic Name: _____	
04	<b>Dependent Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	Primary Care Physician: _____		
	Social Security #: _____ Date of Birth: ____/____/____		Full-time Student: <input type="checkbox"/> Y <input type="checkbox"/> N		Clinic Name: _____		
05	<b>Dependent Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	Primary Care Physician: _____		
	Social Security #: _____ Date of Birth: ____/____/____		Full-time Student: <input type="checkbox"/> Y <input type="checkbox"/> N		Clinic Name: _____		
06	<b>Dependent Name:</b>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	Primary Care Physician: _____		
	Social Security #: _____ Date of Birth: ____/____/____		Full-time Student: <input type="checkbox"/> Y <input type="checkbox"/> N		Clinic Name: _____		

## IV. Health Insurance & Medicare Information

**A.** Will you or any family member(s) continue or maintain any other health or dental insurance in addition to the insurance being applied for today?

Yes  No

**B.** List all health or dental insurance coverage in the last 270 days (18 months for late enrollees). List prescription drug coverage. Failure to provide coverage information may result in a pre-existing condition limitation.

If you attach any/all certificates of creditable coverage you do not need to complete chart below, skip to question C.

Name of Policyholder	Name of Insurance Company	Type of Coverage [family or single]	Type of Plan [medical, dental or prescription drug (Rx)]	Effective Date of Coverage	Cancellation Date
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx		

### IMPORTANT NOTICE REGARDING PRE-EXISTING CONDITIONS

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 270 days (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 270-day (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Customer Service Department.

**C.** Are you or any family members eligible for Medicare?

Yes  No If Yes, please complete the following or attach a copy of your Medicare card.

Reason:  Age 65 or Older  Disability  ESRD (End Stage Renal Disease) onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Medicare Card #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_ Rx BIN #: \_\_\_\_\_

If you do not have Part B, it is because:  You did not elect coverage  You were found ineligible

Part D Effective Date: \_\_\_\_\_ Part D Carrier: \_\_\_\_\_

If you do not have Part D, it is because:  You did not elect coverage  You were found ineligible

Reason:  Age 65 or Older  Disability  ESRD (End Stage Renal Disease) onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Medicare Card #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_ Rx BIN #: \_\_\_\_\_

If you do not have Part B, it is because:  You did not elect coverage  You were found ineligible

Part D Effective Date: \_\_\_\_\_ Part D Carrier: \_\_\_\_\_

If you do not have Part D, it is because:  You did not elect coverage  You were found ineligible

## V. Waiver of Coverage

I have decided not to apply for coverage offered for Medical:  Employee  Spouse  Children  
Dental:  Employee  Spouse  Children

Please check if any of the following apply:

- I am covered or will be covered under another plan that is **not** sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- My dependents are covered or will be covered under another plan that is **not** sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- Other: \_\_\_\_\_

## DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan at a later date if I, or my dependents, lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I understand that I must request enrollment within 31 days after my or my

dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself and my dependents. However, I must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request a special enrollment or obtain more information, please contact our Customer Service Department.

Signature of Employee: \_\_\_\_\_ Date Signed: \_\_\_\_\_

## VI. Applying for Coverage

**TERMS AND CONDITIONS:** The availability of any coverage to the Applicant and/or spouse is determined by the Group's inclusion of that coverage in the Group's plan of insurance. The coverages, if so included, are provided by the following companies: Blue Cross Blue Shield of Wisconsin and/or Compcare Health Services Insurance Corporation. Such companies shall hereinafter be referred to as "insurer(s)." ■ All statements and answers in this form and in the Subscriber Medical Information form are representations made by the Applicant on behalf of himself/herself and the dependents, if any, named herein to induce the issuance of the contract(s) applied for. The contents of this form are to be solely relied upon by the Insurer(s) exclusive of the knowledge of an agent or employee of the Insurer(s). ■ The Applicant and/or spouse on behalf of himself/herself and the dependents, if any, named herein, agree(s) to cooperate in providing the Insurer(s) with information needed to process this form. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent health care records to the Medical Information Bureau, the Insurer(s) or their legal representatives. ■ No person except an officer of the Insurer(s) is authorized to vary or modify a contract. ■ Subject to the acceptance of this Application by the Insurer(s), the Applicant authorizes the Employer to deduct from the Applicant's wage or salary his/her portion, if any, of the premium for the coverages applied for and to timely remit such portion to the party designated by the Insurer(s). The money submitted with this Application is accepted by the Insurer(s) as a refundable deposit. The Applicant understands that such acceptance is not an indication of coverage. If the Insurer(s) approve this Application, such money shall be applied to the first month's premium. If not, such money will be refunded to the

Employer. ■ If this Application is accepted by the Insurer(s), and any covered person subsequently ceases to be eligible for coverage under the contract(s) then in effect for such person, then the coverage(s) for such person shall terminate in accordance with the terms of such contract(s). Should such person wish to continue his/her coverage(s) after such termination, the Employer shall furnish him/her with the appropriate applications for the conversion policies then being offered to such persons. It is such person's responsibility to make timely application for such policies. **SELF FUNDED GROUPS** In completing the Application, the Applicant understands that Blue Cross Blue Shield of Wisconsin (hereinafter called Company) is not the insurer of the benefit plan. The Company provides only administrative services, and has no obligation to fund claims. ■ No person except an officer of the Group is authorized to vary or modify a contract. **ALL GROUPS - With respect to ALL coverages, whether insured or self-funded.** The contract(s) applied for will become effective only upon the Applicant's completion of the probationary period, if any, and acceptance of this Application by the Insurer(s)/Company(ies). The Insurer(s)/Company(ies) will notify the Applicant of his/her effective date and issue an identification card. ■ This Application, when approved, and any endorsement, amendment or rider hereto will be made part of the contract(s) applied for. ■ A legible facsimile signature shall have the same force and effectiveness as an original. ■ You are entitled to a copy of the completed authorization for release of medical information. ■ I have read the statements and answers recorded on this application. They are, to the best of my knowledge and belief, true complete and correctly recorded. I agree that they will become part of this application and any contract issued on it.

Signature of Applicant: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Applicant Day Time Phone Number: (\_\_\_\_\_) \_\_\_\_\_

[www.bluecrosswisconsin.com](http://www.bluecrosswisconsin.com)

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