Blue Cross and Blue Shield of New Mexico

P.O. Box 27630
Albuquerque, New Mexico 87125-7630
1-800-432-0750

Group Enrollment/ Change Application

SEE NUMBERED INSTRUCTIONS ON THE BACK OF THIS FORM

❶ Employee's Last Name, First, Middle Initial **(PLEASE PRINT CLEARLY)**		Social Security or ID #		Date Hired/Rehired	Effective Date
Mailing Address	City	State	Zip Code	Employer **SWCHWT**	Group No. **N35136**
Physical Address	City	State	Zip Code	Job Title	No. of Hours Worked Weekly

Home Phone	Work Phone	E-mail Address	Marital Status ❑ Single ❑ Married ❑ Divorced

❷ New Enrollment? If yes, check one:
❑ New (Go to #4) ❑ Re-Enrollment (Go to #4) ❑ Switch Enroll (Go to #4) ❑ Special Enrollment (explain)__________

❸ Change to Coverage/Contract? If yes, check all that apply:
❑ Enrolled in Medicare ❑ Terminated Medicare (circle one): Part A Part B Both ❑ Other Medicare change (explain)
____
❑ Termination of Contract* ❑ Add or Drop Dependent* (list all additions/deletions in #5) ❑ Name Change* ❑ Address Change ❑ PCP Change
***Reason For Change** (circle one): Marriage Divorce Birth Adoption Death Other (explain)
____

DATE OF CHANGE TO COVERAGE/CONTRACT:__________ (date subject to approval/eligibility)

❹ **Health Plan**

Other **SWCHWT HMO**

Health Coverage Type (if applicable)
❑ Employee ❑ Emp/Spouse
❑ Emp/Child ❑ Family
❑ Emp/Children

❺ **List all members to add/drop** Last Name / First / Initial	Add/Drop (A/D)	Relationship	Sex M/F	Date of Birth Mo/Day/Year	Primary Care Physician (PCP) **(for HMO members only**)**	PCP#	Current patient? Yes	No
Employee		SELF						
Legal Spouse								
Legal Dependent								
Legal Dependent								
Legal Dependent								
Legal Dependent								

NOTE: If a dependent child is over age, indicate if the child is eligible due to student status **(self-insured groups only)** or a handicapping disability.
If spouse has different last name, check applicable box (if common-law, provide affidavit): ❑ Common-law ❑ Wife retaining maiden/professional name. **See additional instructions on reverse regarding legal documentation required for adoptions, divorces, court orders, marriages, etc.**

****All HMO members MUST select a Primary Care Physician; HMO members who do not will have coverage only for *life-threatening emergencies.***

❻ **EXISTING Health Insurance:** Is anyone listed above covered under any of the following? If yes, we will send you an Other Coverage questionnaire to complete.
Other **GROUP** health coverage, government program, or HMO? ❑ No ❑ Yes **NONGROUP** coverage? ❑ No ❑ Yes **MEDICARE?** ❑ No ❑ Yes
If you or any covered dependent is covered by **Medicare**, or has had a change in Medicare entitlement, provide the following information (also see #2, above):

Name Used for Medicare	Part A Eff. Date	Part B Eff. Date	Social Security No.	HIC Number	Reason(s) for Entitlement
					❑ Age 65 ❑ ESRD ❑ Disabled ❑ ESRD & Dis.
					❑ Age 65 ❑ ESRD ❑ Disabled ❑ ESRD & Dis.

❼ **PRIOR Health Insurance:** If you or your dependents were covered under another health plan within the last several months, please complete below and attach a certificate of prior creditable health care coverage from your previous health care insurer: **N/A**

Name	Start Date of Prior Coverage	Paid-Through-Date	Type (Family/Individual)	Employer Sponsoring Prior Group Coverage	Prior Carrier

❽ **EMPLOYEE AUTHORIZATION FOR PAYROLL DEDUCTION/DEPENDENT CERTIFICATION:** I apply for the coverage offered to me and my dependents shown above and authorize my employer to periodically deduct from my earnings, until further notice, amounts equal to the required contributions. I understand that services will be available subject to the exclusions, limitations, and conditions described in the group member's certificate/benefit booklet. I certify that the above information is correct to the best of my knowledge and belief. I also certify that the above-named children are dependent on me for more than 50 percent of their support in a normal parent-child relationship.

Employee's Signature ____________________ Date __________

Office Use Only	UW				
	Date received	Date processed	❑ Contract ❑ Dependent	Change Code	Effective Date

	Cert./I.D. No.	Group No.	BCBS ED	Contract Code					

Copy ❑ Membership Accounting Copy ❑ COB Copy ❑ Group

Group Enrollment/Change Application Instructions

Please follow these directions carefully to ensure that all necessary information is included in your application. Incomplete applications delay processing.

❶ Complete the employee-specific information at the top of the form: name, social security or identification number, date hired/rehired, group number (if applicable), etc. **PLEASE PRINT CLEARLY.**

❷ If you are enrolling for coverage, indicate if you are a new applicant, are re-enrolling, or are switching to a different product being offered by your group. If you are currently covered and requesting a change, go to Item #3.

❸ If you are requesting a *change* in your current coverage or are changing the Medicare information we have on file for you or a covered family member, indicate the type of change (e.g., termination, name change, adding a dependent). Indicate the requested effective date for the change in your coverage and the reason for the change (when applicable). For example, if you are adding or dropping a dependent, give the date the dependent was acquired (e.g., date of birth, adoption, or marriage) or the date the dependent lost his/her eligibility (e.g., due to marriage or divorce).

❹ The coverage choice will vary from employer to employer. Please review the information in your enrollment materials or check with your benefits coordinator to make sure that you understand the coverage available through your group.

If your employer has offered you a choice of health plans (for example, an HMO plan or an indemnity plan), you **must** indicate which plan you are selecting.

If you are eligible for Medicare and your employer offers a “secondary to Medicare” plan, indicate your eligibility for the plan here. (**Note:** Employers with 20 or more employees must offer workers and their spouses age 65 and over the **same** coverage offered to younger workers and spouses. In such cases, you may accept or reject your employer’s regular health plan. However, if you reject it, your employer **cannot** offer you coverage that supplements Medicare.)

Indicate the type of health coverage you want. (**Note:** Not all coverages and not all coverage types may be available to you. Check with your benefits coordinator.)

❺ Complete the name, relationship, sex, and date of birth for you and, if applicable, your dependents. **Any dependents not listed will not be entitled to benefits.** For some groups, a **child over 19 years** old must be a full-time student at an accredited educational institution or incapable of self-support because of mental or physical handicap to be eligible. For other groups, dependent children are eligible until age 25 (end of month). If you list a child who is over age 19, we will send you the appropriate certification form to complete. If the form is not completed and approved, over-age children will not be covered. **Common-law marriages** are not recognized in the state of New Mexico. However, a cohabiting but unmarried partner may be considered a spouse if the marriage was validly established in a jurisdiction that recognizes common-law marriages. Proof of the marriage contract from the other state must be provided. If enrolling a **dependent with a different last name** or **adding a new dependent** who is not your natural newborn child, you must provide documentation that establishes the child’s or spouse’s dependency (e.g., marriage certificate, adoption papers, and court orders). If removing a spouse due to **divorce,** submit a copy of the divorce decree.

If adding or dropping a dependent, list the member’s name and either “A” or “D” in the “Add/Drop” column.

HMO members only: You must select a Primary Care Physician (PCP) from the list provided by HMO New Mexico. Members failing to select a PCP will have coverage only for life-threatening emergencies. Check “yes” or “no” if you and/or your dependents are or are not a current patient of the selected physician.

❻ Provide the requested information for you or any of your dependents who have group or individual insurance coverage, insurance through a government agency or Medicare, or a continuation of coverage (federal- or state-mandated) policy from a previous employer. If you indicate other coverage, we will send you an Other Coverage questionnaire to complete.

❼ If you or any dependents were covered under another health plan within the last several months, but you will have terminated such coverage by the time this coverage is expected to become effective, provide the requested information.

❽ Sign and date the application before submitting it to your benefits coordinator.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.