ENROLLMENT APPLICATION

STATE CHAMBER OF OKLAHOMA

☐ Open Enrollment

Effective Date of Benefits ______/______/______

Last Name	First Name	MI (opt)	Suffix	Birth Date (MMDDYYYY)	Social Security #

Mailing Address - Street - Apt #	City	State	ZIP code

Name of Employer	☐ Male ☐ Female	Employment Date (MMDDYYYY)	Phone Number

Health Coverage (select one)	**Who is covered? (select one)**	**BlueCare Dental Coverage**	**Dearborn National Vision Coverage**	**Who is covered? (select one)**
☐ Blue Advantage PPO℠ (Available 7/1/2019) ☐ Blue Preferred PPO℠ ☐ Blue Options PPO℠ ☐ Blue Options Select PPO℠ ☐ Other ________________ Plan # (required) ________________	☐ Employee Only ☐ Employee / Spouse*** ☐ Employee / Children ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required) ________________	☐ Yes ☐ No Plan # (required) ________________	☐ Employee Only ☐ Employee / Spouse*** ☐ Employee / Children ☐ Family ☐ I am not applying for Health coverage

Employee / Enrollee's Name	Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner

Dependent's Social Security #	Birth Date (MMDDYYYY)	Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Birth Date (MMDDYYYY)

Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Birth Date (MMDDYYYY)

Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Birth Date (MMDDYYYY)

Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Birth Date (MMDDYYYY)

Address (if different) - # and Street Address	City	State	ZIP code

*** The term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).

DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage – Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage – Carrier: _____ ☐ Other (explain) _____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain) _____ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is underwritten or administered by Blue Cross and Blue Shield of Oklahoma. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct.
- I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the
- Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Applicant's Signature _____ Date _____