

SVSU - Blue Cross/Blue Shield and HealthPlus (Health, Dental and/or Vision Insurance Enrollment/Change Form)

Action to Be Taken (Check One)									
New hire___	Transfer___	Open Enrollment___	Retiree___ Resigned___	Newborn ___	Marriage ___ Divorce ___	COBRA___	Name Change ___ Address Change ___	Other: ___	Effective Date
Health Insurance Enrollment (Check One) – If waiving medical coverage do no check									Check if waiving coverage
BCBS PPO-1 Plan 1 ___	BCBS PPO-1 Plan 2 ___	BCBS PPO-3 Plan 1 ___	Healthplus POS (318100002) ___	Healthplus HMO (318100000) ___	Retirees Only Plan Type ___	BCBS Dental ___	BCBS Vision ___	Rebate: Dental ___ (SS only) Medical ___	
Employee Name:		Social Security No.		Address:			City/State/Zip:		
Phone:		Marital Status:	Sex:	Date of Hire:		Date of Birth:	Primary Care Physician: (HealthPlus Only)		
List of all person(s) to be added/removed from coverage:		Social Security #	Date of Birth	Sex (M/F)	Circle One	Enrollment (Check all that apply)	HealthPlus members must select a Primary Care Physician		
Spouse:					Add/Delete Add/Delete Add/Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	First_Last Name		
Dep.1					Add/Delete Add/Delete Add/Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	First_Last Name		
Dep.2					Add/Delete Add/Delete Add/Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	First_Last Name		
Dep.3					Add/Delete Add/Delete Add/Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	First_Last Name		

If you are adding a spouse and/or dependents, you will be required to submit a Xerox copy of your marriage license and birth certificate(s).

Coordination of Benefits Information

Do you, your spouse, or dependents maintain other health coverage? Yes No If yes, complete below: Check here if this applies to all members on the contract.

Person covered	Group Name	Policy number	Carrier	Address

Are any listed members enrolled in Medicare? No Yes If Yes, check category Over 65 and working Retired Disabled ESRD

Medicare Part A effective date: ___/___/___ Medicare Part B effective date: ___/___/___

COBRA - Address for discontinued member: _____

I have read and understand the conditions of this form:

_____ *Employee Signature* _____ *Date* _____ *Employer Representative Signature* _____ *Date*