



Empire Blue Cross Health Insurance Enrollment Form

Date _____
 Subscriber Name _____
 Address _____

 Phone () _____
 Email (optional) _____

District: _____
 ID# or SSN: _____
 Date of Birth _____
 Marital Status _____
 Active / Retired (circle one) DOR: _____

Reason For Change ("X")	
<input type="checkbox"/>	Open Enrollment
<input type="checkbox"/>	Loss of Coverage
<input type="checkbox"/>	Over-Age dependent
<input type="checkbox"/>	Marriage
<input type="checkbox"/>	Newborn / Adoption
<input type="checkbox"/>	Employee Status Change
<input type="checkbox"/>	Termination of Employment
<input type="checkbox"/>	Divorce
<input type="checkbox"/>	Other Coverage
<input type="checkbox"/>	LOA / FMLA / LWOP
<input type="checkbox"/>	Death
<input type="checkbox"/>	Other:

Delete / Change from: (circle one)	
Indicate choice with an "X"	
<input type="checkbox"/>	PPO
<input type="checkbox"/>	Alt PPO
<input type="checkbox"/>	HRA
<input type="checkbox"/>	Trust Gold
<input type="checkbox"/>	Dental
<input type="checkbox"/>	

Indicate choice with an "X"	
<input type="checkbox"/>	Single
<input type="checkbox"/>	Employee/Spouse
<input type="checkbox"/>	Parent/Child
<input type="checkbox"/>	Family
<input type="checkbox"/>	Medicare Individual
<input type="checkbox"/>	Medicare 2 Person (1) Prim
<input type="checkbox"/>	Medicare 2 Person (2) Prim
<input type="checkbox"/>	Medicare Family

Type of change ("X")	
<input type="checkbox"/>	Add Spouse / Dependent
<input type="checkbox"/>	Remove Spouse / Dependent
<input type="checkbox"/>	Address change
<input type="checkbox"/>	Name Change
<input type="checkbox"/>	Plan Change
<input type="checkbox"/>	Medicare Eligible
<input type="checkbox"/>	Terminate Per Member
<input type="checkbox"/>	COBRA / Age 29
<input type="checkbox"/>	Reinstate
<input type="checkbox"/>	Other:
<input type="checkbox"/>	Request Cards Only

Add / Change to : (circle one)	
Indicate choice with an "X"	
<input type="checkbox"/>	PPO
<input type="checkbox"/>	Alt PPO
<input type="checkbox"/>	HRA
<input type="checkbox"/>	Trust Gold
<input type="checkbox"/>	Dental
<input type="checkbox"/>	

Indicate choice with an "X"	
<input type="checkbox"/>	Single
<input type="checkbox"/>	Employee/Spouse
<input type="checkbox"/>	Parent/Child
<input type="checkbox"/>	Family
<input type="checkbox"/>	Medicare Individual
<input type="checkbox"/>	Medicare 2 Person (1) Prim
<input type="checkbox"/>	Medicare 2 Person (2) Prim
<input type="checkbox"/>	Medicare Family

Medicare ID# _____ Date: Part A _____ Part B _____

Indicate with an "X" the person(s) to change

First	MI	Last	SSN	DOB	Gender
<input type="checkbox"/>					M F
<input type="checkbox"/>					M F
<input type="checkbox"/>					M F
<input type="checkbox"/>					M F

Applicant Signature

GBA Signature

X _____

X _____

BCO use only	Date Processed:
	Initials: