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APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

GROUP ADMINISTRATOR: You must complete all areas in the box below before submitting this application to Capital BlueCross.

Employer's Name CDL Labor Logistics		
Group Name *(if different from above)*		
Group Number	Subgroup Number	Class
Does Employer employ 20 or more employees under the MSP laws?		☐ Yes ☐ No
Does Employer employ 100 or more employees under the MSP laws?		☐ Yes ☐ No
Employer's Address *(for Association Groups Only)*	Member Firm ID	
	Effective Date of Above	
Effective Date of Coverage/Change: 2/1/15		
Date Hired:	Has waiting period been met? ☐ Yes ☐ No	

TYPE OF ACTIVITY

☐ Enrollment ☐ Change of Enrollment ☐ Termination

REASON CODES *(See back for codes and descriptions)*

☐ Open Enrollment		
☐ Initial Eligibility Change:	CODE	Date of Change
☐ Life Status Change:	CODE	Date of Change
☐ Termination:	CODE	Date of Change
☐ Other (Please Explain)		Date of Change

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION

Subscriber Identification	Birth Date		☐ Male ☐ Female
Subscriber Name (Last, First, M.I.)			☐ Single ☐ Married
Mailing Address (Include street address, city, state and ZIP Code)		New Address? ☐ Yes ☐ No	
		County	
Home Phone Number	Cell Phone Number	Work Phone Number / Ext.	Home Email Address

Employment Status:
☐ Active (Full-Time) ☐ Retired—(Date) ________ ☐ Hourly ☐ Exempt ☐ Union
☐ Active (Part-Time) ☐ Other—(Explain) ________ ☐ Salary ☐ Non-Exempt ☐ Non-Union

Average Number of Hours Worked Per Week

2. ENROLLMENT/CHANGE INFORMATION / 3. COVERAGE SELECTION/CHANGE / 4. PHYSICIAN OF CHOICE

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	PPO	PPO *Plus*	POS	HMO	Senior	Drug	Dental	Vision	Indicate Practice Names & Codes (Refer to Applicable Provider Directory)
SUBSCRIBER			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Other			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No

If you need an alternate address for a spouse or dependent, please see No. 2 on the INSTRUCTION SHEET.

Physician of Choice selection required for *POS* and *HMO*, optional for PPO *Plus*.

5. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Please list the starting date for each reason in the applicable date field. *(Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)*

Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s) Hospital (Part A)	Effective Date(s) Medical (Part B)	Reason/Effective Date for Medicare coverage: ☐ Age	☐ Disabled	☐ ESRD
				Effective Date:	Effective Date:	Effective Date:
				Effective Date:	Effective Date:	Effective Date:

6. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. *(Please attach a separate sheet of paper if additional space is needed.)*

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

8. STUDENT INFORMATION

Complete the following information for DEPENDENTS who are enrolled as a full-time student at an accredited school or college/university. *(Please attach a separate sheet of paper if additional space is needed.)*

Student's Name	Name of School or College/University	Expected Graduation Date

9. CHANGE THE FOLLOWING INFORMATION

Change is for ☐ Subscriber ☐ Dependent (Name)

Name	From	To
Birth Date	From	To
Social Security Number	From	To

10. STATEMENT OF APPLICATION

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature ____________ Date ____________

NF-2 (10/2013)

White - Capital BlueCross Copy Yellow - Group Administrator Copy Pink - Subscriber Copy