HEALTH

Enrollment Application – The Auburn University Health Plan – Blue Cross and Blue Shield of Alabama*

PLEASEPRINT:USEBLACKBALLPOINTPEN –PRESS FIRMLY

EMPLOYEENAME(LAST) (FIRST) (INITIAL)				EMPLOYEE'S DATE OF BIRTH
STREET ADDRESS CITY STATE ZIP		PHONENUMBER		GROUPNUMBER **37655**
CHECKONE: ☐ MALE ☐ FEMALE	CHECK ONE: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SPONSOR ☐ WIDOWED	CHECK ONE: ☐ Dr. ☐ Mrs. ☐ Miss ☐ Mr. ☐ Ms.	EMPLOYEE'S SOCIAL SECURITY NUMBER	

TYPE OF MEDICAL COVERAGE SELECTED: ☐ INDIVIDUAL ☐ EMPLOYEE & SPOUSE (OR SPONSORED ADULT) ☐ EMPLOYEE & CHILD(REN) ☐ FAMILY

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.
NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

LAST NAME FIRST NAME INITIAL	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH MONTH	DAY	YEAR
1.	☐ SPOUSE ☐ SPONSOREDADULT	☐ MALE ☐ FEMALE				
2.	☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
3.	☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
4.	☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
5.	☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				

NATURE OF APPLICATION ––

CONTRACT APPLICATION	**CHANGE CONTRACT**	**ADD DEPENDENT**	**REMOVE DEPENDENT**
☐ New Coverage	☐ Name Change	☐ Add Spouse	☐ Remove Spouse
CANCEL CONTRACT	☐ Address Change	☐ Add Dependent Child	☐ Removed Child
☐ Medical Coverage	☐ Type of Coverage Change	☐ Add Sponsored Adult Dependent	☐ Removed Sponsored Adult
	☐ Change COB Information	☐ Add Sponsored Child Dependent	☐ Removed Sponsored Child

DATE EVENT OCCURRED: (Example: Date of marriage, birthdate of child, etc)

COORDINATION OF BENEFITS INFORMATION –– If you, your spouse, or your dependents are covered by any other group health insurance please give the following information.

NAME OF CONTRACT HOLDER _____

POLICY, ID, CONTRACT OR CERTIFICATE NUMBER _____ TYPE COVERAGE ☐ INDIVIDUAL ☐ FAMILY

NAME OF INSURANCE COMPANY _____

ADDRESS _____

EMPLOYER'S NAME CITY _____ GROUP# _____

IS ANY MEMBER ENTITLED TO MEDICARE BENEFITS?
PART A ☐ YES ☐ NO **PART B** ☐ YES ☐ NO **PART D** ☐ YES ☐ NO MEDICARE # _____

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Group Health Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application you will send me an ID Card. My group's contract with you is made up of 1) my Group application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you directly and give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up the rights to service if I have not told the complete truth everywhere in this application. You may take back monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand any intentional material misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is to return my fees I paid. You may pay providers directly for service to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process of any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or my family member) or be reimbursed, I will give it to you.

By signing this application, I certify that all dependents are eligible for coverage under the terms of the Group Plan for which I am applying.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____ DATE EMPLOYED _____

SIGNATURE AND TITLE OF EMPLOYER REPRESENTATIVE (Employer's Verification of Applicant Employment) _____ DATE SIGNED _____ EMPLOYERPHONENUMBER _____

EMPLOYER'S NAME	EMPLOYER'S ADDRESS
AUBURN UNIVERSITY	**HUMAN RESOURCES PAYROLL AND EMPLOYEE BENEFITS** **1550 East Glenn Ave, AUBURN, AL 36849-5126**

Auburn University

Tobacco Usage Certification

(For The Auburn University Health Plan)

Employee Name (please print)	Address (City, State, Zip Code)	
Banner ID #	Date of Birth	Email address

In order to qualify for the annual tobacco free discount of $240, please indicate below the tobacco usage status of you and/or your covered spouse or Sponsored Adult Dependent. To receive the annual discount each question pertaining to you and/or your spouse or Sponsored Adult Dependent must be answered no.

- If you are enrolled in the plan, have you used tobacco products within the last 3 months?
  ☐ Yes ☐ No
- If your spouse is enrolled in the plan, has your spouse used tobacco products within the last 3 months?
  ☐ Yes ☐ No
- If you have a Sponsored Adult Dependent who is enrolled in the plan, has your Sponsored Adult Dependent used tobacco products within the last 3 months?
  ☐ Yes ☐ No

An alternative method for compliance is for the individual(s) who have used tobacco products to complete the "Pack it Up" tobacco cessation program sponsored by Healthy Tigers and the Auburn University Pharmaceutical Care Center. For more information call (334) 844-4099 or email aupcc4u@auburn.edu. Certified completion of the "Pack it Up" program will result in participation in the discounted non-tobacco rate upon the pay period following completion of the "Pack it Up" program and remittance of the Tobacco Usage Certification form.

EMPLOYEE CERTIFICATION

"I declare that the above information is true and accurate. I understand that I am responsible for notifying Auburn University Human Resources Payroll and Employee Benefits immediately upon a change in tobacco use status for either me or my spouse (or Sponsored Adult Dependent, if applicable). I also understand that any employee submitting false information may be required to repay all discounts received and may be required to pay all assessed claims and expenses incurred by Auburn University related to false and/or misleading information."

_____ _____

Employee Signature Date