



MC-UA Local 119 Health Plan – Application for Enrollment

THIS FORM MUST BE COMPLETED IN ORDER FOR YOU AND YOUR ELIGIBLE DEPENDENTS TO HAVE COVERAGE UNDER THE HEALTH PLAN.

EMPLOYEE NAME (LAST)		(FIRST)	(INITIAL)	EMPLOYEE'S DATE OF BIRTH
MAILING ADDRESS			CITY	STATE
			ZIP	GROUP NUMBER 17226
CHECK ONE: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHECK ONE: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	EMPLOYEE'S SOCIAL SECURITY NO.	PHONE NUMBER

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER
 *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	SOCIAL SECURITY NUMBER	DATE OF BIRTH		
					MONTH	DAY	YEAR
			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				

NATURE OF APPLICATION –

<input type="checkbox"/> NEW CONTRACT APPLICATION	CHANGE CONTRACT <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Type of Coverage Change <input type="checkbox"/> Change COB Information	ADD DEPENDENT <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child	REMOVE DEPENDENT <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Divorce <input type="checkbox"/> Remove Dependent Child
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DATE EVENT OCCURRED (Example: Date of marriage, birth date 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	GROUP NUMBER	TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY	NAME OF INSURANCE COMPANY
CONTRACT, POLICY, ID, OR CERTIFICATE NUMBER	COVERAGE EFFECTIVE DATE	EMPLOYER'S NAME	EMPLOYER'S STREET ADDRESS/CITY/STATE/ZIP
NAME OF MEMBER(S) ENTITLED TO MEDICARE BENEFITS <input type="checkbox"/> PART A <input type="checkbox"/> PART B	MEDICARE EFFECTIVE DATE	MEDICARE NUMBER	

CURRENT BLUECROSS COVERAGE – If you or your spouse are currently covered by a BlueCross and BlueShield contract and wish to transfer to this group, please complete below:

CURRENT BLUECROSS AND BLUESHIELD CONTRACT NUMBER _____

CITY AND STATE OF BLUECROSS PLAN ENROLLED _____

I waive my rights to benefits and do not wish to enroll.

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

I apply for the MC-UA Local 119 Health Plan (the "Plan"). I understand that my application is subject to the terms and conditions of the Plan and the agreement between the Plan and BlueCross and BlueShield of Alabama. I understand that coverage is subject to the eligibility rules and plan of benefits as stated in the MC-UA Local 119 Health Plan Summary Plan Description. I agree to provide all information needed to administer the Plan and agree to abide by all rules. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law. I understand that coverage under the MC-UA Local 119 Health Plan will not start until my application is accepted by evidence of issuing an Identification Card or other written notice. I agree to notify the Plan Manager, Alabama Administrators, if an Eligible Dependent has a change in status and especially if a dependent is no longer a dependent due to a divorce. I agree that benefits may be paid direct to providers of service and such payment will release the Plan of its benefit obligation. I authorize my doctor, hospital, or anyone else to give all medical records for anyone covered under my coverage to the Claims Administrator for the operation of the Plan including determination of eligibility and benefits. I agree to cooperate with the Claims Administrator and provide information required to administer the Plan, pay claims, coordinate benefits with other coverage, subrogate against another responsible party, or recover benefits paid in error. Everything in this application is true.

X _____ **X** _____
 SIGNATURE OF EMPLOYEE DATE SIGNED

MC-UA Local 119 Health Plan 1717 Old Shell Road Mobile, AL 36604	Plan Manager: Alabama Administrators Phone: (251) 478-5412 or (800) 221-7025 Fax: (251) 478-0203
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