



- New Application
Change

A. APPLICANT INFORMATION

Form fields for Social Security Number, Name (Last, First, M.I., Title), Date of Birth, Address, Telephone Number, Marital Status, Group Name (IBEW Local Union No. 22/NECA), Group Number (13230), and Date employed with Group.

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? Is spouse terminating other Blue Cross and Blue Shield coverage?

Table with columns: Identification Number, Insured's Name, Relationship (Spouse, Son, Dghtr.), Medicare, Medicaid, Insurance Company's Name.

Policy Start Date, Give Termination Date if Applicable, Give Reason for Termination, If Medicare, Medicare HIC #, Part A effective date, Part B effective date, Reason for entitlement (Age, Disability, End stage renal disease).

B. HEALTH ELECTION FOR NEWLY ELIGIBLE EMPLOYEES

I HEREBY APPLY FOR HEALTH NOTE: THERE IS NO DENTAL
Requested Effective Date:
CHANGE ELECTION FOR CURRENT MEMBERS:
Add new dependent(s)
Remove dependent(s)

C. SPOUSE AND DEPENDENT INFORMATION FOR HEALTH

Table with columns: Full Name (Last, First, M.I.), Social Security Number, Date of Birth (Mo., Day, Year), Sex (M, F), Relation to Employee, Name of School (If Dependent is Age 19 or over), Credit Hours per Semester.

I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void.

Signature of Applicant: Date: