This form can be faxed directly to Capstone at 317-222-3003 or emailed to SCDental@capstonebenefits.com

MEMBERSHIP APPLICATION – SCDA Member Benefits Group

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, An independent licensee of the Blue Cross and Blue Shield Association

1. Please indicate reason for Application: ☐ **New Subscriber(s)** ☐ **Coverage Change** ☐ **Cancel** ☐ **Miscellaneous**
☐ COBRA: ☐ 18-mo. ☐ 29-mo. ☐ 36-mo. (Block 19 must be completed.) ☐ Left Employment ☐ Deceased ☐ Name Change
☐ BeneficiaryChange ☐ Address Change ☐ Social Security Number Change From _____
☐ ID Card Request ☐ Add Dependents ☐ Return From Layoff/Medical Leave ☐ Other _____

2. EFFECTIVE DATE OF ACTION REQUESTED: **MONTH** _____ **DAY** _____ **YEAR** _____ **DATE OF HIRE:** **MONTH** _____ **DAY** _____ **YEAR** _____

3. Type Contract: ☐ Preferred Blue ☐ HSA

IDENTIFICATION

4. Employee — Last Name | First | Initial | Home Telephone No. | Work Telephone No.

5. Mailing Address (Street or P.O. Box) | (City) | (State) | (ZIP Code) | **6.** Social Security No.

7. Name of Employer/Firm | **8.** Firm ID # | **9.** Blue Cross Group Number ☐☐ ☐☐☐☐☐ ☐☐ – ☐ | **10.** Deductible Plan

REASON FOR COVERAGE CHANGE

11. Check appropriate reason; give occurrence date in Block 13:
A ☐ Birth or Adoption
B ☐ Death (Name: _____)
C ☐ Divorce
D ☐ Marriage
E ☐ Other – Explain: _____
F ☐ Attained Reduction Age

12. Name of spouse to be excluded from coverage if applicable _____

13. Occurrence Date or Left Employment Date Mo. Day Yr. _____

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired.

	HEALTH	DENTAL	VISION
S – Single	☐	☐	☐
F – Family	☐	☐	☐
F – Employee/Children	☐	☐	☐
8 – Employee/Spouse	☐	☐	☐

REFUSAL OF HEALTH COVERAGE

01 ☐ Other insurance with BCBS of SC
02 ☐ Insurance with another company
03 ☐ US military coverage
04 ☐ Federally qualified HMO
07 ☐ My spouse's coverage with this group
09 ☐ Other third-party administrator
10 ☐ Planned Administrators Inc.
11 ☐ Non-federally qualified HMO
12 ☐ Covered by Medicare
13 ☐ Covered by CHAMPUS
05 ☐ Other – Explain: _____

15. Email Address (Required)

16. Job title or description:

17. Life and AD&D – $25,000
SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION
Full Name (Last Name, First, Init.): Relationship
Primary Beneficiary(ies): _____
Contingent Beneficiary(ies): _____

18. List All Family Members Covered or Affected By a Change

Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.
YOURSELF:				
Spouse				
Social Security No.				
Child				
Social Security No.				
Child				
Social Security No.				
Child				
Social Security No.				

OTHER INSURANCE INFORMATION

19. Do you or does any member of your family have other health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? ☐ YES ☐ NO
If Yes: MEDICARE A ☐ Effective Date _____ MEDICARE B ☐ Effective Date _____
A. Family Member's Name _____ and Social Security No. _____
B. Name of Insurance Co. _____ Policy No. _____ Effective Date _____
C. Family Member's Employer _____
D. List Names of Covered Persons 1 _____ 2 _____ 3 _____ 4 _____
E. Please circle each type of service covered by this policy: Hospital, Physician/Medical, Prescription Drugs, Dental, Vision

EMPLOYEE CERTIFICATION

20. Employee Certification – I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.

Date: _____ Signature: _____

Revised 11/18)