University of North Alabama

GROUP HEALTH ENROLLMENT/CHANGE FORM

OPEN ENROLLMENT - 2019

EMPLOYEE INFORMATION

EMPLOYEE NAME: _____

Last Name, First Name, MI

GENDER:	TYPE OF MEDICAL COVERAGE SELECTED:	TYPE OF DENTAL COVERAGE SELECTED:
☐ Female ☐ Male	☐ Individual ☐ Employee + Spouse ☐ Family ☐ Employee + Child(ren) ☐ None *(Proof of other coverage required.)*	☐ Individual ☐ Family ☐ None

NATURE OF APPLICATION

☐ New Coverage

☐ Cancel Coverage: ○ Medical ○ Dental

☐ Add/Remove: ○ Add Spouse ○ Add Dependent Child ○ Remove Spouse ○ Remove Dependent Child

Date of Qualifying Event: March 1, 2019 – OPEN ENROLLMENT

DEPENDENT INFORMATION

Please list any dependent that you wish to add to coverage in the spaces below.

	NAME:	RELATIONSHIP: ○ Spouse ○ Dependent Child	SOCIAL SECURITY NUMBER:	TYPE OF COVERAGE: ☐ Medical ☐ Dental
1)		GENDER: ○ Female ○ Male	DATE OF BIRTH:	
2)	NAME:	RELATIONSHIP: ○ Spouse ○ Dependent Child	SOCIAL SECURITY NUMBER:	TYPE OF COVERAGE: ☐ Medical ☐ Dental
		GENDER: ○ Female ○ Male	DATE OF BIRTH:	
3)	NAME:	RELATIONSHIP: ○ Spouse ○ Dependent Child	SOCIAL SECURITY NUMBER:	TYPE OF COVERAGE: ☐ Medical ☐ Dental
		GENDER: ○ Female ○ Male	DATE OF BIRTH:	
4)	NAME:	RELATIONSHIP: ○ Spouse ○ Dependent Child	SOCIAL SECURITY NUMBER:	TYPE OF COVERAGE: ☐ Medical ☐ Dental
		GENDER: ○ Female ○ Male	DATE OF BIRTH:	
5)	NAME:	RELATIONSHIP: ○ Spouse ○ Dependent Child	SOCIAL SECURITY NUMBER:	TYPE OF COVERAGE: ☐ Medical ☐ Dental
		GENDER: ○ Female ○ Male	DATE OF BIRTH:	

TO BE COMPLETED BY EMPLOYEE

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

☐ I am applying for 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).

EMPLOYEE SIGNATURE: _____ **DATE:** _____