MEMBERSHIP APPLICATION

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA, An independent licensee of the Blue Cross and Blue Shield Association
COMPANION HEALTHCARE, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina, An independent licensee of the Blue Cross and Blue Shield Association
COMPANION LIFE INSURANCE COMPANY, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina.

1. Please indicate reason for Application: ☐ **New Subscriber(s)** ☐ **Coverage Change** ☐ **Cancel** ☐ **Miscellaneous**

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

3. Type Contract: ☒ Preferred Blue

IDENTIFICATION

4. Employee — Last Name | First | Initial | Home Telephone No. | **5.** Social Security No.

6. Mailing Address (Street or P.O. Box) | (City) | (State) | (Zip Code) | (County Code - see back)

7. Name of Employer
Presbyterian College

8. Blue Cross Group Number
☐☐ – ☐☐☐☐☐ – ☐☐ – ☐

9. Dept. No.

10. Payroll No.

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.

S – Single ☐
F – Family ☐
F – Employee/Children ☐
8 – Employee/Spouse ☐

15. 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

16. 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

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

Date: _____ Signature: _____