

**APPLICATION**  
ALL BLOCKS MUST BE COMPLETED FOR  
APPLICATION TO BE PROCESSED

PLEASE PRINT

LAST NAME FIRST MI

STREET ADDRESS

CITY STATE ZIP CODE

JOB TITLE DATE OF BIRTH  MALE  FEMALE

SOCIAL SECURITY NUMBER  SINGLE  MARRIED  DIVORCED  WIDOWED DATE OF MARRIAGE OR DIVORCE

TYPE COVERAGE APPLYING FOR

MEDICAL / PRESCRIPTION DRUG CARRIER #: 89513-0002

INDIVIDUAL  
 FAMILY

I WISH TO:  BECOME A SUBSCRIBER  ADD DEPENDENT  CHANGE TO COBRA  
 TRANSFER TO THIS GROUP  DELETE DEPENDENT  CHANGE TO DISPLACED WORKER  
 CHANGE NAME  CHANGE COVERAGE TO:  CHANGE TO RETIREE GROUP  
 CHANGE ADDRESS  INDIVIDUAL  FAMILY

COMPLETE DEPENDENT(S) INFORMATION ONLY IF APPLYING FOR FAMILY COVERAGE. NAMES MUST BE ENTERED EXACTLY AS THEY APPEAR ON SOCIAL SECURITY CARD.

1. FIRST MIDDLE LAST  
SS NO. RELATIONSHIP SEX BIRTH DATE

2. FIRST MIDDLE LAST  
SS NO. RELATIONSHIP SEX BIRTH DATE

3. FIRST MIDDLE LAST  
SS NO. RELATIONSHIP SEX BIRTH DATE

4. FIRST MIDDLE LAST  
SS NO. RELATIONSHIP SEX BIRTH DATE

IF YOU PRESENTLY HAVE A BLUE CROSS CONTRACT IN EFFECT, PLEASE FURNISH THE FOLLOWING:

I.D. NUMBER NAME OF PLAN

IF YOU OR ANY MEMBER OF YOUR FAMILY IS NOW COVERED BY ANY GROUP HEALTH INSURANCE (OTHER THAN BLUE CROSS), PLEASE FURNISH THE FOLLOWING:

ID OR POLICY NUMBER NAME OF INSURED PLACE OF EMPLOYMENT

RELATIONSHIP OF INSURED INSURANCE COMPANY AND ADDRESS  
 SELF  SPOUSE  DEPENDENT

I UNDERSTAND THAT THE GROUP INSURANCE THROUGH WHICH I AM ENROLLING WILL BE EFFECTIVE ON THE DATE SHOWN ON THE IDENTIFICATION CARDS TO BE ISSUED TO ME.

SIGNATURE Date: