BlueCross BlueShield of Illinois

Marmon Healthcare Plan

Eligible Employee

Cerro Wire

ENROLLMENT TYPE: OPEN ENROLLMENT ☐ NEW HIRE ☐ CANCEL ☐ CHANGE ☐

COBRA ☐ Reason: _____ Start Date / / End Date / /

MEDICAL PLAN OPTION: Plan B ☐ Plan D ☐ Plan H ☐ Waive ☐

COVERAGE LEVEL: Employee Only: ☐ Employee + Spouse: ☐ Employee + Dependent(s): ☐ Family: ☐

EMPLOYEE INFORMATION

LAST NAME _____ **FIRST NAME** _____ **MI** _____

ADDRESS _____ **APT #** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

DATE OF BIRTH __/__/____ **SOCIAL SECURITY #** ___-___-____ **GENDER** MALE: ☐ FEMALE: ☐

PHONE _____ **EMAIL** _____

OTHER COVERAGE / MEDICARE INFORMATION

Are YOU covered under your employer's health care plan and also covered by Medicare? **Yes** ☐ **No** ☐ If yes, complete this section.

HIC Number: _____

MEDICARE A: ☐ **MEDICARE B:** ☐ **End Stage Renal Dialysis (ESRD):** ☐ **DISABILITY:** ☐

START DATE: / / **END DATE:** / /

FAMILY INFORMATION

FAMILY COVERAGE INFORMATION: List all Eligible Dependents and Type of Coverage.

Name (Last, First, MI)	Social Security Number	Date of Birth	Medical (Y/N)	Dental (Y/N)	Gender	Relationship
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				

If any of the dependents listed above are covered by any OTHER GROUP COVERAGE, please complete the information below.

INSURED'S NAME _____ **POLICY NUMBER** _____

INSURANCE COMPANY NAME _____

EMPLOYED BY _____ **INDIVIDUAL** ☐ **FAMILY** ☐

INSURANCE COMPANY ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____ **PHONE** _____

If any of the dependents listed above are covered by MEDICARE, please complete the information below.

MEDICARE A: ☐ **MEDICARE B:** ☐ **End Stage Renal Dialysis (ESRD):** ☐ **DISABILITY:** ☐

HIC NUMBER **START DATE** / / **END DATE** / /

APPLY FOR COVERAGE AS INDICATED ABOVE, for which I am or may become eligible under the agreement with Health Care Service Corporation. I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Employee Signature _____ Date _____

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Employee Signature _____ Date _____

OFFICE USE ONLY

COVERAGE EFFECTIVE DATE: _____/_____/_____ **DATE OF HIRE:** __/__/____ **Coverage Change Date:** _____/_____/_____

COMPLETED and CHECKED by: _____

COMPANY NAME _____ **LOCATION:** Cerro Wire - AL / GA / IN / UT

MEDICAL GROUP # (if Enrolled): _____

MEDICAL SECTION # (if Enrolled): _____

MEDICAL Group Number : _____

MEDICAL Section Number : _____

Employee Type: _____
HR - Hourly
SE - Salaried Exempt
SN - Salaried Non-Exempt

Employee Status: _____
A Active
C COBRA
L LTD

Union Status: _____
U - Union
N - Non-Union