

APPLICATION FOR ENROLLMENT / WAIVER

Please print in black or blue ink in all unshaded areas. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." The form must be signed and dated or it will be returned.

EMPLOYEE INFORMATION	Network: <input type="checkbox"/> BCBS <input type="checkbox"/> HealthWise <input type="checkbox"/> ValueCare <input type="checkbox"/> HMOBlue	Product: <input type="checkbox"/> BlueEssentials <input type="checkbox"/> BlueClassic <input type="checkbox"/> BluePreferred	Dental: <input type="checkbox"/> BCBS <input type="checkbox"/> ValueCare <input type="checkbox"/> Life <input type="checkbox"/> Vision	Other: <input type="checkbox"/> Existing Enrollee <input type="checkbox"/> New Enrollee or Transferring from _____	Health Group Number
	Employee Name (Last) (First) (Initial)			Social Security Number	Daytime Number
	Mailing Address			Employer	
	City State ZIP Code		Work Location (City/State)		Occupation

Effective Date	Membership Status	Adult Code	Family Members	Special Code	Medically Underwritten
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Relationship to Applicant	Name(s) of Member(s) to be covered (include last name if different from Applicant) No nicknames, please	Social Security # for each Member covered	Birthdate Mo/Day/Yr	Relationship to Applicant	Name(s) of Member(s) to be covered (include last name if different from Applicant) No nicknames, please	Social Security # for each Member covered	Birthdate Mo/Day/Yr
Self <input type="checkbox"/> M <input type="checkbox"/> F			/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /
Spouse <input type="checkbox"/> M <input type="checkbox"/> F			/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			/ /

MEDICARE If you or any family members listed on this application have Medicare, is coverage PART A or PART B, and please complete the following information:

Member	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement <input type="checkbox"/> age <input type="checkbox"/> disability <input type="checkbox"/> ESRD
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OTHER COVERAGE Do you or any family members listed on this application, have GROUP or INDIVIDUAL coverage other than the coverage applied for above?

Medical Coverage? YES NO Prescription (Rx) Coverage? YES NO Dental Coverage? YES NO With Orthodontia? YES NO Vision Coverage? YES NO

If the answer to any of the above questions is "Yes," please complete the section below. If you have more than one additional policy, please provide this information on a separate sheet.

OTHER INSURANCE INFORMATION	Name of Policyholder with other coverage		Relationship	Policyholder birthdate / /	Name of other group insurance plan	Daytime Number	
	Address of other coverage City State ZIP Code		This coverage is for <input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
	Number that identifies you to other Group Plan (Group ID, Member Numbers, etc.)		This Plan covers <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> StepChild(ren) <input type="checkbox"/> Other Please list names				
	Name of Employer		<input type="checkbox"/> Continuation <input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date	Termination date		

	Name(s) of Member(s) Waiving Coverage (include last name if different from Applicant) No nicknames, please	Birthdate Mo/Day/Yr	Other Health Insurance		Type of Insurance			Insurance Carrier Name
			Yes	No	Group	Individual	Other (explain)	
Employee		/ /						
Spouse		/ /						
Children		/ /						
		/ /						
		/ /						

BENEFICIARY DESIGNATION If your employer offers Group Life administered by Regence BlueCross BlueShield of Utah, please complete the following information:

First Name	Last Name	Birthdate / /	Social Security Number	Relationship	Benefit %
Primary		/ /			%
Primary		/ /			%
Contingent		/ /			%
Contingent		/ /			%

Dependent Life YES NO STD Benefit YES NO LTD Benefit YES NO Supplemental Life/Amount YES NO \$ Supplemental AD&D/Amount YES NO \$ Other YES NO \$

EARNINGS Weekly Monthly Annually

\$ _____

Life Group No. _____
Class _____ Life Amount _____

Please complete the following information about any health insurance coverage you and/or your dependents have had at any time during at least the past 24 months. Write "None" if there has been no coverage. Obtaining credit for previous coverage is subject to your eligibility under Public Law 104-191 Section 101 and, therefore, is not guaranteed by the completion of this application. Failure to complete all information and submit a timely "Certificate of Coverage" form or this form with the initial "Application For Membership," may jeopardize or delay your ability to obtain credit for prior coverage for which you and/or your dependents otherwise would have been eligible. Complete this section even if you and/or your dependents have had no prior coverage.

Prospective enrollees applying for prior coverage credit.

(List below all enrollees to be considered for prior coverage credit and all corresponding insurance policies.)

CREDITING PRIOR COVERAGE

Name (First, Last)	Birth Date	Prior Insurer Name	Prior Insurer Policy #	Prior Insurer Phone #	Prior Health Coverage From - Thru Mo/Day/Yr - Mo/Day/Yr	Was this proposed enrollee covered under this policy?	
						Yes	No
1.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
2.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
3.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
4.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
5.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
6.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
7.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
8.	/ /				/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>

INSTRUCTIONS

WAIVING MEMBERS	<ul style="list-style-type: none"> Complete this section for yourself (if waiving) and/or any of your eligible dependents for whom you are waiving coverage. You may not enroll dependents if you are waiving (except children subject to a Qualified Medical Child Support Order). If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (the Special Enrollment Period). Please complete type of insurance coverage for the employee and all eligible members who have other health insurance coverage by completing type of insurance [group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.)]. All eligible family members must be listed in either Enrolling or Waiving Members section.
LIFE	<ul style="list-style-type: none"> If your employer offers Group Life administered by Regence Life & Health, P.O. Box 1271 MS E3A, Portland, OR 97207 (<i>domiciled in Oregon</i>), indicate your chosen beneficiary and his/her relationship to you. If more than one beneficiary is desired, be sure to include the additional name(s) and their relationship(s). If Dependent Life, STD, LTD, Supplemental Life and Supplemental AD&D is/are offered by your employer, administered by Regence BlueCross BlueShield of Utah, complete the appropriate section(s). Salary information is required only for life programs which are based on the individual's income.

I authorize any source to release to Regence BlueCross BlueShield of Utah, Regence ValueCare, and/or Regence HealthWise (hereinafter referred to as "the Plan"), any medical, health, employment and/or insurance information requested for any enrolled member. I authorize payroll deduction of premiums as required. I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the Plan.

I understand there may not be participating providers in all specialty fields.

Any eligible family member not listed on this application will be considered as having waived coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING MEMBERS section above (or any eligible family member not listed). In waiving coverage, I am aware that waiving members (including me, if I am waiving) may later enroll only at my group's anniversary, unless qualified for a Special Enrollment Period.

If I apply for life insurance, I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false or incomplete, Regence BlueCross BlueShield of

Utah, and/or its subsidiaries may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of, the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Employee's Signature

Date