Fillable Adobe File
- Please complete entire form
- Print and Sign bottom (required)
- Submit for processing

Empire Blue Cross Health Insurance Enrollment Form

Date	District:
Subscriber Name	ID# or SSN:
Address	Date of Birth
	Marital Status
Phone ( )	Active / Retired (circle one) DOR:
Email (optional)	

	Reason For Change ("X")
	Open Enrollment
	Loss of Coverage
	Over-Age dependent
	Marriage
	Newborn / Adoption
	Employee Status Change
	Termination of Employment
	Divorce
	Other Coverage
	LOA / FMLA / LWOP
	Death
	Other:

Delete / Change from: (circle one)

	Indicate choice with an "X"
	PPO
	Alt PPO
	HRA
	Trust Gold
	Dental

	Indicate choice with an "X"
	Single
	Employee/Spouse
	Parent/Child
	Family
	Medicare Individual
	Medicare 2 Person (1) Prim
	Medicare 2 Person (2) Prim
	Medicare Family

Effective Date:

	Type of change ("X")
	Add Spouse / Dependent
	Remove Spouse / Dependent
	Address change
	Name Change
	Plan Change
	Medicare Eligible
	Terminate Per Member
	COBRA / Age 29
	Reinstate
	Other:
	Request Cards Only

Add / Change to : (circle one)

	Indicate choice with an "X"
	PPO
	Alt PPO
	HRA
	Trust Gold
	Dental

	Indicate choice with an "X"
	Single
	Employee/Spouse
	Parent/Child
	Family
	Medicare Individual
	Medicare 2 Person (1) Prim
	Medicare 2 Person (2) Prim
	Medicare Family

Medicare ID# Date: Part A Part B

Indicate with an "X" the person(s) to change

	First	MI	Last	SSN	DOB	Gender	
						M	F
						M	F
						M	F
						M	F

Applicant Signature

X

GBA Signature

X

BCO use only	Date Processed:
	Initials: