Application for Coverage

Wyoming Educators Benefit Trust

- ☐ Initial Enrollment
- ☐ Decline Coverage(s)
- ☐ Add Dependent(s) to Existing Coverage

DEDUCTIBLE:

- ☐ $1,000
- ☐ $2,500
- ☐ $2,500 HDHP

PLEASE COMPLETE IN FULL, EVEN IF ADDING NEWBORN.

Date of Marriage (if applicable) ____/____/____

Date Dependent Was Acquired ____/____/____
(Date of birth, adoption, etc.)

Claims Supervisor:

BlueCross BlueShield of Wyoming
An independent licensee of the Blue Cross and Blue Shield Association

P. O. Box 2266
Cheyenne, WY 82003

Please print, using black ink, and initial all corrections; do not use correction fluid or correction tape.

GENERAL INFORMATION

NAME OF EMPLOYER	DATE EMPLOYED FULL TIME MM/DD/YYYY : / /	HRS WORKED PER WEEK
EMPLOYEE MARITAL STATUS ☐ MARRIED ☐ SINGLE	EMPLOYEE JOB TITLE	

HEALTH COVERAGE ENROLLMENT OR DECLINATION

☐ I wish to enroll for the WEBT health coverage offered by my employer.
I wish to cover
☐ Myself ☐ Myself & My Spouse ☐ Myself & My Dependent Child(ren) ☐ Myself, Spouse & Dependent Child(ren)

☐ I am **declining** my employer's WEBT health coverage on behalf of the following (print name and Social Security # for all individuals for whom you are declining):_____

I am declining due to:
- ☐ the existence of other group coverage
- ☐ the existence of other individual coverage
- ☐ other reason (explain) _____

SIGN ONLY IF YOU HAVE DECLINED ANY COVERAGE. I have had the Enrollment Regulations of my employer's WEBT health coverage explained to me and I understand if I delay in making application for myself and/or any eligible dependents until after the initial period of eligibility I and/or my eligible dependents will only be able to enroll during the annual open enrollment period at which time we will be subject to the late enrollee provisions as stated in my Employer's Benefit Document. I further understand that I and/or any eligible dependents may be eligible later for a special enrollment as provided by applicable law.

Signature_____ Date_____

FAMILY INFORMATION

RELATIONSHIP	FAMILY MEMBER'S NAME – List all family members to be covered (attach additional page if necessary) Last / First / MI	SEX	DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY #
EMPLOYEE				
SPOUSE				

STREET ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE
MAILING ADDRESS	CITY	STATE	ZIP	WORK TELEPHONE

For Blue Cross Blue Shield Office Use Only

Class_____ GRP/Roll_____ AD_____ Probationary Period_____

OED_____ BCBS_____ DSC_____

REQUIRED INFORMATION RELATED TO HEALTH COVERAGE

1. Please attach any applicable "Creditable Coverage Certificates" available for any individuals applying for coverage on this application.

2. Please complete the following for ALL individuals named on this application who currently have, or who had in the past year, other health coverage. Attach extra pages which you have signed and dated, if necessary.

   Policyholder's Name:_____ Covered Individuals:_____

   Name of Insurance Company:_____

   Insurance Company Address: _____

   Policy #:_____ Coverage Began (MM/DD/YY):_____ Ended (MM/DD/YY):_____

   If still in effect, will the coverage described above be cancelled when this coverage becomes effective? ☐ Yes ☐ No
   If yes, give reason for cancelling coverage _____

   If no longer in effect, did the coverage described above terminate for ANY of the following reasons: Termination of employment; Termination of the employer's contribution to coverage; Termination of the other health plan's coverage with the employer; Death of a spouse; Divorce or Legal separation? ☐ Yes ☐ No

A. I understand that upon acceptance of this application, coverage will become effective on the date established by the WEBT and that the Benefit Document, together with this application and attachments, if any, shall constitute my/our entire agreement with the Wyoming Educators' Benefit Trust.

B. I affirm that I have reviewed all answers given on this application and, regardless of whether any other individual has filled out the answers for me, I verify that the answers are true and complete. I REALIZE THAT ANY ACT, PRACTICE, OR OMISSION I HAVE PERFORMED THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT ASKED FOR ON THIS APPLICATION WILL RENDER THE CONTRACT NULL AND VOID OR SUBJECT TO CANCELLATION, RESCISSION, OR TO DISALLOWANCE OF THE INDIVIDUAL ABOUT WHICH THE FRAUDULENT ACT, PRACTICE, OMISSION, OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT OCCURRED.

C. I apply for coverage with the Wyoming Educators' Benefit Trust under the terms and conditions as stated in the Benefit Document, ***including the coordination of benefits provision and the Pre-existing Conditions waiting period, if applicable.***

I HAVE READ AND UNDERSTAND ITEMS A – C ABOVE, **INCLUDING** THE REFERENCE TO ANY PRE-EXISTING CONDITIONS WAITING PERIOD THAT MAY BE CONTAINED IN THE BENEFIT DOCUMENT.

SIGN BELOW ONLY IF YOU ARE **APPLYING** FOR COVERAGE.

APPLICANT'S SIGNATURE_____ DATE_____

APPLICATION WILL NOT BE PROCESSED IF RECEIVED MORE THAN 60 DAYS AFTER DATE OF SIGNATURE

You are applying for coverage that contains comprehensive adult wellness benefits as defined by the Wyoming Insurance Code. For a further description of these benefits, please refer to the Benefits Section of your Employer's Benefit Document.

IMPORTANT: Please be certain you have answered ALL questions on this application.