PPO & BLUE EDGE HSA
HEALTH PLAN ENROLLMENT FORM

ENROLLMENT

☐ New Enrollment
☐ Re-Enrollment
☐ Special Enrollment

PLAN SELECTION

☐ MBI PPO Plan
☐ BlueEdge HSA Plan

COVERAGE LEVEL ELECTED

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

EMPLOYEE INFORMATION *(Please print all information)*

Employee Name (First, Initial, Last)	Social Security	Birth Date

Street Address	City	State	Zip

Home Phone	Sex	Marital Status	Hire Date
( ) -	☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced	

Effective Date of NEW or RE-Enrollment: _____ **Effective Date of CHANGE/SPECIAL ENROLLMENT:** _____

I was covered under another health insurance plan from: _____ to: _____ Name of Plan: _____

DEPENDENT COVERAGE ELECTION

Name of Spouse (First, Initial, Last)	Birth Date	Social Security	Sex	Relationship	College Attending (Children Only)
Name(s) of Child(ren) (First, Initial, Last)	**Birth Date**	**Social Security**	**Sex**	**Relationship**	**College Attending (Children Only)**

Upon coverage effective date, will you or any family member be enrolled in another HMO or insurance plan? ☐ Yes ☐ No

Name of Insured Person	Birth Date	Employer/Group Sponsor for Other Insurance

Other Insurance Company Name	Address	Plan Number

I HEREBY APPLY for benefits under the plan selected above, subject to all of its terms, conditions, and provisions. I authorize the necessary deductions from my earnings.

Employee Signature: _____ Date: _____

HR Use Only: *Entered HCM:* _____ *Date:* _____ *Entered BCBS:* _____ *Date:* _____