PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
2550 Denali Street, Suite 1404
Anchorage, AK 99503-2737

BRH Enrollment and Change Form

Part 1. Employee Information

Employer Name	Employee Social Security Number	Employee Birth Date
Employee Name (LAST) (FIRST) (MI)	Home Phone	Marital Status ☐ Single ☐ Married
Mailing Address	Work Phone	
	City	State / Zip

Part 2. Must Be Completed by BRH Human Resources

☐ Union ☐ Non-Union

Medical Group No.	Dental Group No.	Date of Hire	Effective Date
9001328	**4020278**		

Please check appropriate enrollment box and provide date:

☐ New Employee	☐ Rehired Employee	☐ Open Enrollment	☐ Transfer from other Plan
☐ Entered Eligible Class	☐ Marriage	☐ Divorce	☐ Birth
☐ Dependent Change	☐ Medical Child Support Order	☐ Adoption	☐ Death
☐ Active to Retired Status	☐ Loss of Other Coverage	☐ Other Reason:	

Part 3. Product Selection (Please Check Applicable Boxes)

Economy Plan	Standard Plan	Basic Dental Plan	Dental Buy Up
☐ Employee **$0 biweekly**	☐ Employee **$95.00 biweekly**	☐ Employee **No additional cost**	☐ Employee **$18.95 biweekly**
☐ Family **$138.20 biweekly**	☐ Family **$205.40 biweekly**	☐ Family **No additional cost**	☐ Family **$31.13 biweekly**

Part 4. Enrollment

Add	Drop	Relationship to Employee	Name (Last, First, Middle Initial)	SSN	Gender (M/F)	Birthdate MM/DD/YY	Mentally / Physically Disabled
☐	☐	Self					**N/A**
☐	☐	Spouse					**N/A**
☐	☐						☐ Yes
☐	☐						☐ Yes
☐	☐						☐ Yes
☐	☐						☐ Yes
☐	☐						☐ Yes

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature _____ Date Signed _____