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 **$70 biweekly** | ☐ Employee **No additional cost** | ☐ Employee **$12.46 biweekly** |
| ☐ Family **$88.20 biweekly** | ☐ Family **$155.40 biweekly** | ☐ Family **No additional cost** | ☐ Family **$24 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 _____