CBJ Enrollment and Change Application

2550 Denali Street, Suite 1404
Anchorage, AK 99503-2737

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Part 1. Employee Information

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

Part 2. Must Be Completed By City Of Juneau

Medical Group No.	Work Location	Date of Hire	Effective Date
9001303			

Please check appropriate Enrollment box and provide date:

☐ New Employee ☐ Rehired Employee ☐ Open Enrollment

☐ Transfer From Other Plan ☐ Employee Entered Eligible Class

Date: _____

Part 3. Product Selection (Please Check Applicable Boxes)

Economy Plan	Standard Plan	Premium Plan	Dental Plan**
☐ Employee	☐ Employee	☐ Employee	☐ Employee
☐ Family	☐ Family	☐ Family	☐ Family
			☐ Waive Dental

Please Check Appropriate Special Enrollment And Provide Date:

☐ Marriage ☐ Divorce ☐ Active to Retired Status ☐ Involuntary Loss of Other Coverage/Reason _____

☐ Birth ☐ Dependent Change ☐ Adoption (Legal Documents Required) ☐ Other/Reason _____

☐ Death ☐ Medical Child Support Order Date _____

Part 4. Enrollment

Add	Drop	Relationship to Employee	Name (Last, First, Middle Initial)	Social Security Number	Gender (M/F)	Birthdate Mo / Day / Yr	Medicare Effective Date, if applicable	Mentally / Physically Disabled	Medical /Dental Plan Name AK Global/ Standard	
☐	☐	Self					Part A _____ Part B	N/A		
☐	☐	Spouse					Part A _____ Part B	N/A		
☐	☐						Part A _____ Part B	☐ Yes	If yes, complete disabled dependent form.	
☐	☐						Part A _____ Part B	☐ Yes	If yes, complete disabled dependent form.	
☐	☐						Part A _____ Part B	☐ Yes	If yes, complete disabled dependent form.	
☐	☐						Part A _____ Part B	☐ Yes	If yes, complete disabled dependent form.	
☐	☐						Part A _____ Part B	☐ Yes	If yes, complete disabled dependent form.	

Prior Carrier Name and Phone Number (if more than one carrier, please attach a separate sheet with this info)	ID/Policy Number	Date Prior Coverage Began	Date Prior Coverage Ended

Name of Persons Covered By Prior Coverage:

Part 5. Other Coverage Information

Will the coverage listed above be in effect after the coverage with this plan begins? ☐ No ☐ Yes

If yes, please be sure to complete the prior carrier information above so this information can be provided to our coordination of benefits department.

Are you currently enrolled under another Premera Blue Cross Blue Shield of Alaska group plan? ☐ No ☐ Yes

If you are, should we terminate that coverage? ☐ No ☐ Yes

If any dependent children are covered under another plan and the natural parents are divorced or separated, please provide the following:

Name of parent with custody (indicate if parents have dual custody): _____

If divorced, did the court establish financial responsibility for the child(ren)'s health care? ☐ No ☐ Yes

If yes, please specify the name and address of the parent with responsibility: _____

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