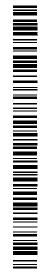


## Enrollment Application - The Auburn University Health Plan - Blue Cross and Blue Shield of Alabama\*

PLEASE PRINT: U	ISE BLACK BALL F	POINT PEN – PRE	SS FIRMLY								
EMPLOYEE NAME (LAST)				(FIRST)	(FIRST) (INITIAL)			EMPLOYEE'S DATE OF BIRTH			
STREET ADDRESS CITY		CITY	STATE	ZIP	PHON	NE NUMBEF	R	GROUP N			33503
CHECK ONE:  MALE FEMALE	CHECK ONE: ☐ SINGLE ☐ SPONSOR	□ DIVORCED	CHECK ONE: ☐ Mrs. ☐ Mr.	□ Dr. □ Miss □ Ms.	SOCI	SOCIAL SECURITY NUMBER		CHECK ONE: PPO HDHP			
TYPE OF MEDIC	AL COVERAGE S	SELECTED: ILL	NDIVIDUAL IT	EMPLOYEE	& SP0	OUSE (OR S	PONSORED ADULT) [	1 FMPI OYFF	& CHII I	D(RFN) [	1 FAMILY
TITE OF MEDIO							ROVIDE SOCIAL SI				717(((()))
NOTE: The							provided in order fo		cation to	be proc	
LAST NAME	FIRST	NAME	INITIAL	RELATION	SHIP	GENDER	SOCIAL SECURIT	Y NUMBER	MONTH	ATE OF BI	YEAR
1.				☐ SPOUSE ☐ SPONSORE	) ADULT	□ MALE □ FEMALE			MONTH	DAT	TLAN
2.				□ CHILD □ SPONSOREI	) CHILD	□ MALE □ FEMALE					
3.				□ CHILD □ SPONSORE	CHILD	□ MALE □ FEMALE					
4.				□ CHILD □ SPONSORE	) CHILD						
5.				☐ CHILD☐ SPONSORED	CHILD	☐ MALE ☐ FEMALE					
NATURE OF A	PPLICATION —									1	
CONTRACT	APPLICATION	С	HANGE CONTR	RACT		ADD DEP	ENDENT	REM	OVE DEF	PENDENT	
□ New Coverage □ Name Change				☐ Add Spouse		□Re	☐ Remove Spouse				
CANCEL CO			Address Chang	•			pendent Child		move Ch		
☐ Medical Co	overage		Type of Covera	-			onsored Adult Depen			onsored A	
			Change COB I			□ Add Sp	onsored Child Depen	ident LI Re	emove Sp	onsored C	hild
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COORDINATIO	N OF BENEFITS	INFORMATION	following in		your d	ependents a	re covered by any ot	ner group nea	aitti itiSuta	arice pieas	e give trie
NAME OF CONTRACT HOLDER											
POLICY, ID, CONTRACT OR CERTIFICATE NUMBER TYPE COVERAGE   INDIVIDUAL   FAMILY										FAMILY	
NAME OF INSURANCE COMPANY											
ADDRESS											
EMPLOYER'S N						CITY GR			SROUP#	ROUP#	
	R ENTITLED TO	) MEDICARE BE	NEFITS?		_						
PART A   YE		RTB	□ NO PAR1	r <b>d</b> □ YES	3 <b>0</b> N	10	MEDICARE #				
I am requesting cancellation of my existing benefits as checked above.  I apply for the Group Health Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application you will send me an ID Card. My group's contract with you is made up of 1) my Group application to you; 2) the Group Health Benefits Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. Wy coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you directly and give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up the rights to service if I have not told the complete truth everywhere in this application. You may take back monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand any intentional material misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.  If you do not accept my application, the only thing you have to do is to return my fees I paid. You may pay providers directly for service to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone list of give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone list of give all medical records of me or my family to you. You may release those incl											
SIGNATURE OF EMPLOYEE					DATE SIGNED DATE EMPLOYED		OYED				
CICNATURE AND 3	TITLE OF EMPLOYE	D DEDDECENTATIV	E (Emplements Marks 12	inn of Avellers 1	F1	DATE:	CICNED	EMDLOVED	חוסייב י	II IMPED	<b>↓</b> =
SIGNATURE AND TITLE OF EMPLOYER REPRESENTATIVE (Employer's Verification of Applicant Employment) DATE SIGNED EMPLOYER PHONE NUMBER								┦≣			

**AUBURN UNIVERSITY** 

**Human Resources, Payroll & Employee Benefits** 1550 East Glenn Avenue, Auburn, AL 36849



## **Auburn University**

## **Tobacco Usage Certification**

(For The Auburn University Health Plan)

Employee Name (please print)	Address (City, State, Zip Code)								
Employee Name (piease print)	Address (Gity, State, 21p code)								
Banner ID #	Date of Birth	Email address							
In order to qualify for the annual tobacco free discount of \$240, please indicate below the tobacco									
usage status of you and/or your covered spouse or Sponsored Adult Dependent. To receive the annual									
discount each question pertaining to you and/or your spouse or Sponsored Adult Dependent must be									
answered no.									
• If you are enrolled in the plan, have you used tobacco products within the last 3 months?									
Yes No									
• If your spouse is enrolled in th	e plan, has your spouse used	tobacco products within the last 3							
months?									
Yes No									
If you have a Sponsored Adult Dependent who is enrolled in the plan, has your Sponsored Adult									
Dependent used tobacco prod	lucts within the last 3 months	<i>'</i>							
Yes No									
An alternative method for compliance is for the individual(s) who have used tobacco products to									
complete the "Pack it Up" tobacco cessation program sponsored by Healthy Tigers and the Auburn									
University Pharmaceutical Care Ce	nter. For more information o	all (334) 844-4099 or email							
aupcc4u@auburn.edu. Certified completion of the "Pack it Up" program will result in participation in									
the discounted non-tobacco rate upon the pay period following completion of the "Pack it Up" program									
and remittance of the Tobacco Usage Certification form.									
EMPLOYEE CERTIFICATION									
<b></b>									
"I declare that the above information is true and accurate. I understand that I am responsible for									
notifying Auburn University Payroll and Employee Benefits immediately upon a change in tobacco use									
status for either me or my spouse (or Sponsored Adult Dependent, if applicable). I also understand that									
any employee submitting false information may be required to repay all discounts received and may be									
required to pay all assessed claims and expenses incurred by Auburn University related to false and/or misleading information."									
misicaang mormation.									
Employee Signature		Date							