



## INSTRUCTIONS:

1. PRINT HARD WITH BLACK BALL-POINT PEN OR TYPE.
2. COMPLETE AND SIGN APPLICATION.
3. BLUECHIP COORDINATED HEALTH PLAN (BLUECHIP) ENROLLEES: SELECT A PCP FOR EACH MEMBER IN ITEMS 28-30.

MEMBERSHIP APPLICATION  
(Fifty-One or More Eligible Employees)DO NOT  
WRITE  
IN THIS  
AREA

|   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| A1 GROUP  |  |  |  | A2 SUBGRP |  |  |  | A3 CK |  |  |  | A4 LID |  |  |  | APPLICATION RECEIVED DATE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 PLAN DESIRED: <input type="checkbox"/> HEALTHMATE C TO C <input type="checkbox"/> CLASSIC <input type="checkbox"/> BLUECHIP<br><input type="checkbox"/> OTHER |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 2 APPLICATION TYPE: <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 EMPLOYER (GROUP) NAME   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 4 GROUP NUMBER   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 5 EFF. DATE OF COVERAGE                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 6 FOR MEMBERSHIP USE ONLY |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 LAST NAME   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 8 FIRST  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 9 INITIAL   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 10 TITLE (JR, MD, ETC)    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 11 GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 12 CHECK MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WID <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/> COMMON LAW |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 13 BIRTHDATE: MONTH DAY YEAR                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 RESIDENCE ADDRESS STREET, BOX, RT. NO.   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 15 ADDITIONAL ADDRESS (APT., BLDG., ETC.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 16 CITY   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 17 STATE                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 18 ZIP   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19 HOME TELEPHONE (with area code)  |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 20 DATE OF HIRE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 21 OCCUPATION   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22 EMPLOYEE NUMBER        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23 PRIMARY LANGUAGE SPOKEN   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24 NAME (LAST) (FIRST) (MI)   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | 25 BIRTHDATE MO. DAY YR.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 26 SEX  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 27 RELATIONSHIP           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 28 SOCIAL SECURITY NUMBER  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 29 **MANDATORY FOR BLUECHIP COVERAGE: PERSONAL CARE PHYSICIAN (PCP)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 30 ARE YOU A CURRENT PATIENT?                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 31 PCP NUMBER  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | IF STUDENT NAME OF COLLEGE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Admission Mo. Yr. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Please Do Not Write In Shaded Area.   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | SUBSCRIBER   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | FIRST NAME  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | LAST NAME                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | <input type="checkbox"/> YES <input type="checkbox"/> NO                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Please Do Not Write In Shaded Areas.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   |  |  |  |           |  |  |  |       |  |  |  |        |  |  |  | / /  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | <input type="checkbox"/> M <input type="checkbox"/> F |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DEPENDENT                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | FIRST NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | LAST NAME  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |