



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

SPECIAL ENROLLMENT PERIOD (SEP) FORM

MUST BE COMPLETED AND EXECUTED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS, INCLUDING ANY WHO ARE NOT APPLYING FOR COVERAGE

(This application must be accompanied by a "CERTIFICATE OF CREDITABLE COVERAGE" for previous coverage used to qualify for an SEP.)

Name of Employee _____ Social Security Number _____ Name of Employer Group _____

INSTRUCTIONS FOR COMPLETING SECTIONS A, B, C & D										
SECTION A			SECTION B				SECTION C		SECTION D	
<p>Please complete this section for the employee and all eligible family members, whether or not applying for coverage, listing the first and last name and relationship to the employee. Indicate 'yes' or 'no' as to whether the employee or family member had other health coverage at the time he or she was first eligible for coverage under this Group.</p>			<p>Please complete this section for the employee and all family members listed in Section A who did have other health coverage at the time they were first eligible for coverage under this group. List the type of insurance (Group, Individual, Medicare, Medicaid, V.A., etc.); which family member is or was the certificate holder (Employee's or Spouse's Name); the name of the insurance carrier; dates of coverage, and the reason the coverage terminated (COBRA exhausted, legal separation, divorce, death, reduction of hours of employment, elimination of employer contributions, etc.).</p>				<p>Please identify any dependent in Section A acquired within the past 30 days, listing the date acquired and whether acquired by marriage, birth, adoption, or placement for adoption.</p>		<p>If the employee and/or any eligible family member(s) have received initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code (the "UPP" program), please supply the date(s) on which you, he, and/or she received that initial notice and attach a copy of it.</p>	
Name of Employee or Family Member (First & Last)	Relationship to Employee	Other Health Care Coverage		Type of Insurance	Certificate Holder Name and Policy #	Insurance Carrier Name and Policy #	Dates of Coverage From/ Terminated	Reason(s) for Termination	Type and Date of Acquisition	Date of Receipt of Initial Written Notice
Employee: 1.	Self	<input type="checkbox"/>	<input type="checkbox"/>							
Spouse: 2.	Husband <input type="checkbox"/> Wife <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Children: (List in order of age beginning with eldest) 3.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
4.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
5.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
6.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
7.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
8.	Son <input type="checkbox"/> Daughter <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

SIGNATURE

I certify that the above information is true, correct and complete to the best of my knowledge, and I acknowledge that any coverage issued by the Plan will be issued in reliance thereon. I am aware that any family member(s), including me if I am enrolling, must be listed on an "Application for Membership" form. Should any information called for or provided by me in this agreement prove untrue, inaccurate, or incomplete, the Plan shall have the right to declare my contract null and void and deny coverage of any claims incurred.

Employee Signature: _____ Date Signed: _____