BRH Enrollment and Change Form

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 ☐ 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
9001328			

Please check appropriate Enrollment box and provide date:

☐ New Employee ☐ Rehired Employee ☐ Open Enrollment

☐ Transfer From Other ☐ Employee Entered Eligible Class

Plan

Date: _____

Part 3. Product Selection (Please Check Applicable Boxes)

Economy Plan	Standard Plan	Basic Dental Plan	Dental Buy Up
☐ Employee $0 bi-weekly	☐ Employee $70 bi-weekly	☐ Employee No additional cost	☐ Employee $12.46 bi-weekly
☐ Family $88.20 biweekly	☐ Family $155.40 bi-weekly	☐ Family No additional cost	☐ Family $24 bi-weekly

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
☐	☐	Self					Part A _____ Part B	N/A
☐	☐	Spouse					Part A _____ Part B	N/A
☐	☐						Part A _____ Part B	☐ Yes
☐	☐						Part A _____ Part B	☐ Yes
☐	☐						Part A _____ Part B	☐ Yes
☐	☐						Part A _____ Part B	☐ Yes
☐	☐						Part A _____ Part B	☐ 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