

# Application for Coverage



Wyoming Educators'  
Benefit Trust

- Initial Enrollment
- Decline Coverage(s)
- Add Dependent(s) to Existing Coverage

**DEDUCTIBLE:**

- \$1,000
- \$1,500

**PLEASE COMPLETE IN FULL, EVEN IF ADDING NEWBORN.**

Date of Marriage (if applicable) \_\_\_/\_\_\_/\_\_\_

Date Dependent Was Acquired \_\_\_/\_\_\_/\_\_\_  
(Date of birth, adoption, etc.)

**Claims Supervisor:**



**BlueCross BlueShield  
of Wyoming**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

P. O. Box 2266  
Cheyenne, WY 82003

Please print, using black ink, and initial all corrections; do not use correction fluid or correction tape.

**GENERAL INFORMATION**

NAME OF EMPLOYER		DATE EMPLOYED FULL TIME MM/DD/YYYY : / /	HRS WORKED PER WEEK
EMPLOYEE MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	EMPLOYEE JOB TITLE		

**HEALTH COVERAGE ENROLLMENT OR DECLINATION**

- I wish to enroll for the WEBT health coverage offered by my employer.  
I wish to cover  
 Myself       Myself & My Spouse       Myself & My Dependent Child(ren)       Myself, Spouse & Dependent Child(ren)

- I am declining my employer's WEBT health coverage on behalf of the following (print name and Social Security # for all individuals for whom you are declining): \_\_\_\_\_

- I am declining due to:
- the existence of other group coverage
  - the existence of other individual coverage
  - other reason (explain) \_\_\_\_\_

SIGN ONLY IF YOU HAVE DECLINED ANY COVERAGE. I have had the Enrollment Regulations of my employer's WEBT health coverage explained to me and I understand if I delay in making application for myself and/or any eligible dependents until after the initial period of eligibility I and/or my eligible dependents will only be able to enroll during the annual open enrollment period at which time we will be subject to the late enrollee provisions as stated in my Employer's Benefit Document. I further understand that I and/or any eligible dependents may be eligible later for a special enrollment as provided by applicable law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FAMILY INFORMATION**

RELATIONSHIP	FAMILY MEMBER'S NAME -- List all family members to be covered (attach additional page if necessary) Last / First / MI	SEX	DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY #
EMPLOYEE				
SPOUSE				
STREET ADDRESS		CITY	STATE	ZIP
MAILING ADDRESS		CITY	STATE	ZIP
			HOME TELEPHONE	
			WORK TELEPHONE	

**For Blue Cross Blue Shield Office Use Only**

Class \_\_\_\_\_ GRP/Roll \_\_\_\_\_ AD \_\_\_\_\_ Probationary Period \_\_\_\_\_  
OED \_\_\_\_\_ BCBS \_\_\_\_\_ DSC \_\_\_\_\_

## REQUIRED INFORMATION RELATED TO HEALTH COVERAGE

1. Please attach any applicable "Creditable Coverage Certificates" available for any individuals applying for coverage on this application.
2. Please complete the following for ALL individuals named on this application who currently have, or who had in the past year, other health coverage. Attach extra pages which you have signed and dated, if necessary.

Policyholder's Name: \_\_\_\_\_ Covered Individuals: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Coverage Began (MM/DD/YY): \_\_\_\_\_ Ended (MM/DD/YY): \_\_\_\_\_

If still in effect, will the coverage described above be cancelled when this coverage becomes effective?  Yes  No  
If yes, give reason for cancelling coverage \_\_\_\_\_

If no longer in effect, did the coverage described above terminate for ANY of the following reasons: Termination of employment; Termination of the employer's contribution to coverage; Termination of the other health plan's coverage with the employer; Death of a spouse; Divorce or Legal separation?  Yes  No

- A. I understand that upon acceptance of this application, coverage will become effective on the date established by the WEBT and that the Benefit Document, together with this application and attachments, if any, shall constitute my/our entire agreement with the Wyoming Educators' Benefit Trust.
- B. I affirm that I have reviewed all answers given on this application and, regardless of whether any other individual has filled out the answers for me, I verify that the answers are true and complete. I REALIZE THAT ANY ACT, PRACTICE, OR OMISSION I HAVE PERFORMED THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT ASKED FOR ON THIS APPLICATION WILL RENDER THE CONTRACT NULL AND VOID OR SUBJECT TO CANCELLATION, RESCISSION, OR TO DISALLOWANCE OF THE INDIVIDUAL ABOUT WHICH THE FRAUDULENT ACT, PRACTICE, OMISSION, OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT OCCURRED.
- C. I apply for coverage with the Wyoming Educators' Benefit Trust under the terms and conditions as stated in the Benefit Document, **including the coordination of benefits provision and the Pre-existing Conditions waiting period, if applicable.**

I HAVE READ AND UNDERSTAND ITEMS A – C ABOVE, **INCLUDING** THE REFERENCE TO ANY PRE-EXISTING CONDITIONS WAITING PERIOD THAT MAY BE CONTAINED IN THE BENEFIT DOCUMENT.

SIGN BELOW ONLY IF YOU ARE **APPLYING** FOR COVERAGE.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**APPLICATION WILL NOT BE PROCESSED IF RECEIVED MORE THAN 60 DAYS AFTER DATE OF SIGNATURE**

**You are applying for coverage that contains comprehensive adult wellness benefits as defined by the Wyoming Insurance Code. For a further description of these benefits, please refer to the Benefits Section of your Employer's Benefit Document.**

**IMPORTANT: Please be certain you have answered ALL questions on this application.**