Revised
4/9/2025

BCBS_____ VISION_____

Date _____

Initials: _____

CULLMAN COUNTY COMMISSION INSURANCE ENROLLMENT FORM (Medical/Dental/Vision)

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Gender
Social Security Number		Date of Birth	
Mailing Address	City	State	ZIP Code
Primary Telephone Number	Home Email Address	Department	

Employment Status (Check One)

☐ Full-time Employee		☐ Elected Official	☐ Retired (Not Medicare Participant)	

Note: If your Employment Status above is ☒ **Retired**, and you or your covered dependent(s) are covered by Medicare, you must provide a copy of your Red, White, and Blue Medicare Card.

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		

TO BE COMPLETED BY EMPLOYER

Probationary Period: Yes_____No _____

If yes to above: Start Date_____End Date _____

Full-time date of hire:

Payroll Deduction Added: _____

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the Cullman County Commission's behalf.

_____ _____

Employee Signature **Date**

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(**Appropriate documentation must be attached.)****

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced spouse).
2. A child under age 26, only if the child is:
    a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
    b. a child legally adopted by you or your spouse,
    c. your stepchild,

**Documentation Required to Add Dependents to Your Health Coverage

1. Spouse – Copy of marriage certificate, copy of spouse's social security card. (Effective 1/1/2017 common-law marriage is no longer recognized in the State of Alabama)
2. Dependent Child (under age 26) – Copy of child's birth certificate, copy of child's social security card. Copy of court order granting custody of child to you or your spouse (if applicable).

CULLMAN COUNTY COMMISSION
PERSONNEL DEPARTMENT
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CULLMAN, AL 35055

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