



2022 ACA Individual and Family

Step 1: Member Information

Request only for members with ZCU prefix

ID Card #ZCU: _____

Member's Last Name: _____ First Name: _____

Member's Email Address: _____ Member's Phone Number: _____

Step 2: Remove Dependent

Last Name: _____ First Name: _____ SSN: _____ DOB: _____

Last Name: _____ First Name: _____ SSN: _____ DOB: _____

STOP. If no additional changes, please see last page for form submission directions.

Step 3: Address Change

Address Change Yes No

If yes, please document the new residential/rate address.

Street Name: _____

City: _____ State: _____ ZIP Code: _____

STOP. If no additional changes, please see last page for form submission directions.

Step 4: Add Dependent

Last Name: _____ First Name: _____ SSN: _____ DOB: _____

Last Name: _____ First Name: _____ SSN: _____ DOB: _____

In last six months, has any person to be insured, if age 18 or older, used tobacco four or more times a week?

If so, please indicate.

Last Name: _____ First Name: _____

Last Name: _____ First Name: _____

If special enrollment period (SEP), what is the qualifying event?

_____ Date of Event: _____

If adding dependent due to an SEP, please submit SEP documentation with this form.

Members adding or removing dependents may only select plans within their metal level.

Are you keeping your current plan? Yes No

If no, please select your plan on the next page of this document.



Choose One BlueEssentialsSM Plan:

- Gold 1 Gold 2 HD Gold 3 Gold 4 Gold 5 Silver 1
- Silver 2 HD Silver 6 Silver 7 Silver 14 Silver 15 Silver 16
- HD Silver 20 Silver 21 Silver 28 Bronze 1 HD Bronze 2 HD Bronze 3
- Bronze 4 HD Bronze 5 HD Bronze 6 Catastrophic 1

Choose One BlueExclusiveSM Reedy Plan:

These plans are only available in Greenville County:

- Gold 1 Silver 1 Silver 2 Bronze 1

Choose One BlueExclusiveSM Cooper Plan

These plans are only available in Charleston, Dorchester and Berkeley Counties:

- Gold 1 Silver 1 Silver 2 Bronze 1

Choose One BlueExtendSM Plan:

- Gold 1 Gold 2 Silver 1 Silver 2 Bronze 1 Bronze 2

Step 5: Billing information

Has your billing information changed: Yes No Recurring Payment

If billing information has changed, please supply:

Name on checking account: _____

Routing Number: _____ Account Number: _____

Agent Information

Agent ID: _____

Agent Name: _____

Form Submission

When form is complete and necessary documentation gathered, you can send it via:

Secure Email: membership.sep@bcbssc.com (Preferred Method)

Fax: 803-870-9439 Phone: 855-404-6752

Effective dates are assigned based on the Qualifying Life Event that occurred and application submission date.

*We cannot process a change request if SEP documentation is not included. Please submit SEP documentation within 14 days of submitting this form.
We will not process incomplete forms.*

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áa háida biká'aná nílwo'ígíí díí Béeso Ách'ááh naa'níligi háá'ida yí na' idíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'ishjį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é la' bich'į́ ha desdzih nínízingo, kojį́ béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)