BlueCross BlueShield Minnesota

Enrollment/Waiver Form

Complete this application in its entirety in blue or black ink. Do not use pencil or highlighter.

❑ **Enrolling** (Complete sections I, II, IV, and V)
❑ **Waiving** (Complete sections I and III)

I Employee/Contract Holder Information (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll location

First Name	MI	Last Name	*Social Security Number *(if no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one):*
❑ Single/Widowed
❑ Married

Enrollment Status
❑ Active Employee ❑ COBRA Continuant Start Date _____ / _____ / _____
❑ Rehired Employee ❑ HIPAA Life Event

Full-Time Hire (or Rehire) Date *(mm/dd/yyyy)*
/ /

Hours Worked Per Week

Gender	Date of Birth *(mm/dd/yyyy)*	Age	Product Selection(s):
❑ Male ❑ Female	/ /		❑ Medical Product Name: _____ ❑ Dental

*** Social Security Numbers (SSN) for you and your dependents are requested but not required.**

II Dependent Information (If enrolling more than four dependents, please attach a separate sheet)

Spouse / Domestic Partner

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner †

*Social Security Number *(if no SS#, write N/A)*	Gender	Date of Birth *(mm/dd/yyyy)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s): ❑ Medical ❑ Dental

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage license.
† If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

Dependent #1

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted^ ❑ Other^

*Social Security Number *(if no SS, write N/A)*	Gender	Date of Birth *(mm/dd/yyyy)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s): ❑ Medical ❑ Dental

Dependent Status if Age 26 or Older: ❑ Disabled

Dependent #2

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted^ ❑ Other^

*Social Security Number *(if no SS, write N/A)*	Gender	Date of Birth *(mm/dd/yyyy)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s): ❑ Medical ❑ Dental

Dependent Status if Age 26 or Older: ❑ Disabled

Dependent #3				
First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted^ ❑ Other^	
*Social Security Number *(if no SS, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(mm/dd/yyyy)* / /	Age
Product Selection(s): ❑ Medical ❑ Dental			Dependent Status if Age 26 or Older: ❑ Disabled	

Dependent #4				
First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted^ ❑ Other^	
*Social Security Number *(if no SS, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(mm/dd/yyyy)* / /	Age
Product Selection(s): ❑ Medical ❑ Dental			Dependent Status if Age 26 or Older: ❑ Disabled	

❑ **Additional family members on attached page**

^ If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III Waiver Of Coverage (Complete this section ONLY if you are declining coverage(s) offered to you and/or your family members)

Medical

I Hereby Decline Medical Coverage:
- ❑ For myself
- ❑ For family members ONLY
- ❑ For myself and ALL family members
- ❑ For the following family members:

_____
_____

Reason For Declining Medical Coverage:
- ❑ Spouse/Domestic Partner group coverage
- ❑ Individual coverage
- ❑ Group coverage continuation
- ❑ No other health coverage ❑ Medicare
- ❑ Medical Assistance
- ❑ General Assistance Medical Care
- ❑ TRICARE ❑ Other: _____

Dental

I Hereby Decline Dental Coverage:
- ❑ For myself
- ❑ For family members ONLY
- ❑ For myself and ALL family members
- ❑ For the following family members:

_____
_____

Reason For Declining Dental Coverage:
- ❑ Other dental coverage
- ❑ No other dental coverage

I hereby acknowledge that I have been given the opportunity to participate in the group health and/or dental plans provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment event occurs before coverage will be offered.

_____ _____

Employee/Contract Holder Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order, you may be able to enroll yourself and your eligible dependents. In order to avoid claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Special enrollment may also be available as a result of a marriage, provided that you request enrollment within 30 days after the marriage.

IV Other Health Insurance Coverage

Other Group or Non- Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder

Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ❑ Active ❑ Retired Date of Retirement: __ /__ /___

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V Important: Authorized Signature Required

Read this section, sign and date the application. Blue Cross and Blue Shield of Minnesota and/or Blue Plus hereinafter referred to as The Company, will act in reliance on the information you provide on this application.

For the purposes of the application, I understand and agree that 'employee' is defined as only those individuals subject to FICA and other tax withholding, and performing services for compensation for the employer listed in Section I of this application.

In order to process this application, The Company may collect personal information regarding me or my family members listed on this application. The information collected by The Company or The Company's authorized agents may in certain circumstances be disclosed to third parties without authorization. I have the right to see my personal records that are maintained by The Company and to correct personal information The Company has collected about me or my family members listed on this application. Upon my request, The Company will furnish a more detailed notice of The Company information practices. The Company keeps this information confidential, but may release it if I authorize release, or if state or federal law permits or requires release without authorization. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid as long as I am continually insured with the insurer. I am entitled to receive a copy of any release I sign.

I agree if I am enrolling in a product that features certain designated providers, The Company may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I've received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

The Company primarily relies upon the information provided and full disclosure of the information listed on this application in the decision whether to accept me and my family members listed on this application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all required questions in the application, even if I and/or my family members listed on this application currently have coverage or had prior coverage with The Company.

I understand and agree that payment of a claim does not preclude the right of The Company to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I understand that the medical plan does not include coverage for the pediatric dental essential health benefit and that The Company has made me aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit www.mnsure.org.

I agree to notify The Company immediately of any change in my or my family member's enrollment information between the date of this application and the effective date of coverage. Failure to notify The Company of any change in the information contained on this application may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

Upon request, I agree to furnish any additional information needed concerning the eligibility of any family member applying for coverage.

V Important: Authorized Signature Required - Continued

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree The Company will act in reliance upon the information I have provided on this application and that any false information, omissions or misstatements on this application which materially affect enrollment eligibility may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

If this application is completed as an electronic or online application form, both parties agree to conduct this transaction electronically.

Print Employee/Contract Holder Name	Print Employer/Group Name
Employee/Contract Holder Signature	Date

- Please contact your employer's Agent or Broker for assistance or call 651-662-5035 or toll free at 1-888-878-0138 and one of our Blue Cross representatives will be happy to assist you.
- This information is available in other ways for people with disabilities who need it translated into another language by calling 1-800-382-2000 (toll free). For TTY, call 711.
  Hours: 7 a.m. to 8 p.m., Central Time, Monday through Friday.
- Attention: If you want free help translating this information, call the above number.
  Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Blue Cross Small Group Sales Contact.

Open Enrollment - Employees and dependents who want the effective date of their coverage to be on the annual renewal date of the employer's plan must submit this application during the 30 day period before the annual renewal date.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to the following address:

Fax (651) 662-7258

www.bluecrossmn.com

Blue Cross and Blue Shield of Minnesota
P.O. Box 64024
St. Paul, MN 55164-0024