BlueCross BlueShield Minnesota



# Application For Individual Dental/Vision Insurance

## Please Complete Steps 1-6.

***If you are an insurance agent/producer, please complete Steps 1-7.***

**Step 1)** Tell us about yourself.
**Step 2)** Tell us about your household.
**Step 3)** Coverage and payment selection.
**Step 4)** Tell us if you have other dental and/or vision insurance.
**Step 5)** Sign, authorize, and date your Application.
**Step 6)** Send your completed Application (all pages) and payment to Blue Cross and Blue Shield of Minnesota (Blue Cross).
**Step 7)** If you are an insurance agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.

## Need Help?

**This information is available in other ways for people with disabilities or who need it translated into another language by calling** 1-800-531-6685 **(toll free). For TTY, call 711.**

**Need help choosing a plan or completing this Application?**
**For in-person help:** Visit your local Blue Cross Retail Center
**If you work with an insurance agent/producer:** Please contact your Agent or Broker for assistance or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.

**Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.**

## General Information

- You must be a resident of Minnesota. You must obtain our Residency Policy at www.bluecrossmn.com/residencypolicy or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.
- If eligible, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.
- These plans do NOT meet the minimum essential health benefit requirements for pediatric oral health and pediatric vision coverage as required under the Affordable Care Act.
- Please note, Blue Cross may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include any person or entity from which Blue Cross is not required by law to accept such third-party payments. This may include, for example, commercial entities, health care providers and suppliers, and other persons or entities with direct or indirect financial interests. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic fund transfer, etc. If you have questions about this third party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at 1-800-531-6685 before you complete this Application.

To submit your Application faster, please use one of these options to enroll:
- E-mail: enrollment.forms@bluecrossmn.com
- By telephone: 1-877-293-7040

## General Information - continued

- Your coverage will begin on the first day of the month following receipt of your completed Application unless you indicate a different first of the month effective date on page 3 – whichever is later. Requested effective dates must be within 90 days following receipt of your completed Application.
- Complete this entire Application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete Applications will be returned to you to be completed. This may affect the date your coverage starts. Processing of your Application may be delayed if this Application is NOT completed in its entirety*.
- Sign and date this Application. This Application must be received at the home office of Blue Cross within 15 days of your signature. Incomplete Applications are null and void after 30 days.

## STEP 1 - Tell Us About Yourself

☐ Open Enrollment

I have an existing Blue Cross/Blue Plus ID#: _____

I am a new applicant:

☐ Applying for coverage for myself only ☐ Applying for coverage for myself and my dependents

I am currently enrolled in a Blue Cross Dental/Vision Individual Plan:

☐ Adding a dependent ☐ Making a plan change

**Please note: Processing of your Application <u>may</u> be delayed if this form is NOT completed in its entirety*. PLEASE PRINT CLEARLY.**

*Social Security Numbers (SSN) for you and your dependents are requested for benefit administration. Please include SSN with your Application, however, it is not required.

| First Name, Middle Name, Last Name & Suffix | | | |
|---|---|---|---|
| Social Security Number (If no SSN, write N/A) | Sex ☐ Male ☐ Female | | Date of Birth *(mm/dd/yyyy)* |
| Permanent Home Address (No P.O. Box #) | | | Apartment Number |
| City | State | Zip Code | County |
| ☐ Correspondence address (If different from home address) | | | Apartment Number |
| City | State | Zip Code | County |
| ☐ Billing address (If different from permanent home and correspondence address) | | | Apartment Number |
| City | State | Zip Code | County |
| E-mail address | | | |
| Home telephone number (non-mobile) | Work telephone number | | Mobile telephone number |

1. ☐ Yes ☐ No I am a permanent resident of Minnesota since: _____ (mm/dd/yyyy)
2. Will you or any other enrollee receive any premium or cost-sharing payments made by a specific person or entity, directly or indirectly, by any ineligible third-party described on page 1 above? ☐ Yes/Not sure ☐ No

GO TO STEP 2

## STEP 2 - Tell Us About Your Household

Tell us about everyone who is applying for coverage.

| Dependent 1<br>Full Name (First, MI, Last) | Relationship to Applicant | Date of Birth (mm/dd/yyyy) | Social Security Number | Sex |
|---|---|---|---|---|
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 2**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 3**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 4**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 5**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 6**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 7**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |
| **Dependent 8**<br>**Full Name (First, MI, Last)** | **Relationship to Applicant** | **Date of Birth (mm/dd/yyyy)** | **Social Security Number** | **Sex** |
| | | | | ☐ Male<br>☐ Female |
| Does this person live at the same address as you? ☐ Yes ☐ No<br>**If No,** list address: | | | | |

☐ Additional dependent(s) on attached page

GO TO STEP 3

## STEP 3 - Coverage and Payment Selection

| | | |
|---|---|---|
| **Dental Coverage Option:**<br>☐ Freedom ☐ Value Standard<br>☐ Preferred ☐ Value Enhanced<br>☐ Value Premium<br>Bill Frequency Options:<br>☐ monthly ☐ quarterly<br>☐ semi-annual ☐ annual<br>Premium Payment ($): _____ | My Coverage will be for:<br>☐ Contractholder only<br>☐ Contractholder and One Dependent<br>☐ Family | Requested Effective Date: _____ (mm/yyyy)<br>☐ First of the month following<br>☐ Add a dependent<br>List reason for adding dependent outside of renewal. Permitted reasons; newborn, newborn grandchild, adoption/ placement for adoption, court ordered:<br>_____ |
| **Vision Coverage Option:**<br>☐ Value Standard - with Exam<br>☐ Value - Eyewear Only Plan<br>Annual Premium Payment (Annual Billing Only) ($): _____ | My Coverage will be for:<br>☐ Contractholder only<br>☐ Contractholder and One Dependent<br>☐ Family | Requested Effective Date: _____ (mm/yyyy)<br>☐ First of the month following<br>☐ Add a dependent<br>List reason for adding dependent outside of renewal. Permitted reasons; newborn, newborn grandchild, adoption/ placement for adoption, court ordered:<br>_____ |

## STEP 4 - Dental and/or Vision Insurance Information

If you have a current Blue Cross Individual/Family dental and/or vision policy, your current policy will be replaced as of the effective date of your new plan. If your current coverage is through an employer or another insurance carrier, Blue Cross cannot cancel that coverage for you.

1. Have you or any family members applying for coverage under this Application had prior Blue Cross dental and/or vision insurance within the past 3 years? ☐ Yes ☐ No

**REMITTANCE SLIP** **Separate check/payment is required for each dental and vision policy**

Please complete the form below.

Contractholder Name (First, Middle, Last): _____

Telephone Number: ( _____ ) _____ Zip Code: _____ Social Security Number: _____

Monthly Premium for the Dental Coverage Option you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____

Annual Premium for the Vision Coverage Option you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $_____

If you plan to fax/e-mail your Application, separately mail in this page with your first premium payment. Failure to do so may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 6.

| **Applicant's Last Name** | **First Name** |
|---|---|
| | |

## STEP 5 - Authorization Language

My/our signature on this Application indicates that I/we have read and fully understand the following statements when applying for dental/vision coverage through Blue Cross and Blue Shield of Minnesota (Blue Cross): I understand and agree that coverage, if approved, will begin as specified on page 3. I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my check and I will not receive my check back from my financial institution.

I understand that coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

For purposes of obtaining information in connection with this Application, reinstatement, or change in coverage benefits, this release is valid as long as I am continually covered with Blue Cross. I am entitled to receive a copy of any release I sign.

**GO TO STEP 5 Continued**

## STEP 5 - Authorization Language - continued

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the applicant and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the Application, even if I and/or dependent(s) listed on this Application currently have coverage or had prior coverage with Blue Cross. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Cross will rescind my contract and coverage, and no claims will be paid. I further attest that I was not encouraged or advised to apply for this coverage in connection with any offer by an "ineligible third party" (described on page 1) to directly or indirectly pay all or some of my premiums or cost-sharing.

I agree to notify Blue Cross immediately of any change in my (or my dependent(s)) enrollment information between the date of this Application and the effective date of coverage. Failure to notify Blue Cross of any change in the information contained on this Application may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

By providing your e-mail address, you agree to receive communications and/or marketing materials related to the Plan you selected and products offered by or made available from Blue Plus and its affiliates. You may unsubscribe or change your e-mail address at any time by following the instructions included in each e-mail communication.

By providing your telephone number, you expressly consent to accept and receive communications and /or marketing materials related to the Plan you selected and products offered by or made available from Blue Plus and its affiliates, via text message or voice call to your mobile device and to the cellular/mobile telephone number(s) that you provided to us.

WARNING: E-mail and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an e-mail or text message from an unsecured e-mail or device, Blue Plus (individual) / The Company (group), does not accept liability for any errors or omissions in the contents of this message, which arise as a result of e-mail or text message transmission.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependent(s) enrolling for coverage. 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 that my (or my dependent(s)) enrollment eligibility and coverage of benefits under this dental coverage may be subject to waiting periods or a lock-out period. I understand and agree Blue Cross will act in reliance upon the information I have provided on this Application which materially affect enrollment eligibility and may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

I understand and agree that payment of a claim does not preclude the right of Blue Cross 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 this Agreement renews on an annual basis. I acknowledge that if my first payment is not made with this Application, the first premium payment is due by the due date printed on my first invoice. I understand that failing to pay before this due date will result in my application being voided. I understand that payments in advance of the amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received. I acknowledge that if my ongoing premium payments are not received within the plan grace period, my plan will be terminated.

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

Applicant's Signature _____ Date _____

Spouse _____ Date _____



GO TO STEP 6

## STEP 6 - Send Your Completed Application and Payment to Blue Cross

Send in your completed Application and payment to Blue Cross by one of the following methods. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to you, please mark as 'N/A'.

### U.S. Mail:

**Include your completed, signed Application along with your first premium payment to:**

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

### Fax or e-mail:

**Fax your completed, signed Application to 651-662-6439 or e-mail to enrollment.forms@bluecrossmn.com -- *and* -- mail your first premium payment with completed remittance slip to:**

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


### Drop Your Application and Payment Off In Person At Your Local Blue Cross Retail Center:

For locations, please visit www.bluecrossmn.com or call 1-800-531-6685.
You may also visit bluecrossmn.com/centers to make an appointment near you.

**Please Note:** This Agreement renews on an annual basis. You can pay your dental premium monthly in advance to Blue Cross. If it is convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis during the calendar year. These amounts will be subject to premium increases on the date the increase is effective.

You must pay your vision premium annually.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Please note: Processing of your Application may be delayed if this Application is NOT completed in its entirety.

## Step 7 - For Producer Use Only

# PRODUCER'S CERTIFICATE

**ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-888-878-0138.**

If this section is not fully completed, we will not pay a commission.

| Blue Cross Blue Shield Agency No. | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | R | I |

| Producer No. | | | | | | |
|---|---|---|---|---|---|---|
| 4 | 3 | 1 | 0 | | | |

**A PRODUCER must complete this section to act on the applicant's behalf.**

I certify that I have met the requirements listed in Minnesota Statute 60K.46 subdivision 4 regarding suitability, as well as those requirements set forth in the Agent Code of Conduct and within the Blue Cross and Blue Shield of Minnesota contractual agreement. I further understand, no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy or waive Blue Cross and Blue Shield of Minnesota's rights or requirements.

It is your responsibility as a producer to retain a signed copy of this Application for your records.

Agency Name Walter Palmer Agency

Producer's Name Palmer (*LAST*) Walter (*FIRST*) J. (*MI*)

Producer's Signature _____

Business Telephone (612) 825-4990

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Minnesota
3535 Blue Cross Road
Eagan, MN 55122

**INTERNAL USE ONLY**

| Blue Cross Blue Shield Agency No. | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | R | I |

| Producer No. | | | | | | |
|---|---|---|---|---|---|---|
| 4 | 3 | 1 | 0 | | | |

## NOTICE OF NONDISCRIMINATION PRACTICES

***Effective July 18, 2016***

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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