BlueCross BlueShield Minnesota

Small Group Employee Enrollment Form

Applying for coverage

- Fully complete all sections in black or blue ink. Incomplete enrollment forms will be returned to be completed. This may affect the date your coverage starts.
- Existing Groups: In order to avoid delays in the processing of your enrollment form you must provide the correct Group and Subgroup numbers in section A (ask your employer for these numbers). You must also provide the complete Employer Name in section B.
- **Special Enrollment** - Employees and dependents applying for coverage at the time of a special enrollment event must submit this application, along with applicable supporting information, within the required notification time period.
- **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.
- **If your employer offers multiple health plans, make sure you provide the name of the health plan you want in section D.**

Waive coverage (not applying)

- If you are not applying for any coverage, you only need to fully complete sections A, B, D, and G.

Submission instructions

- If your employer is applying as a new group with Blue Cross and Blue Shield of Minnesota and/or Blue Plus (Blue Cross), give the completed enrollment form (even if you are waiving all coverage) to the employer's Agent or Broker or Blue Cross Sales Representative.
- Social Security Numbers (SSN) for you and your dependents are requested for benefit administration and reporting to the Internal Revenue Service (IRS) so you may demonstrate having minimum essential coverage and avoid having to pay a tax penalty. Please include SSNs with your application.
- If your employer has current group coverage with Blue Cross and you are applying for coverage or changing your coverage, mail the completed enrollment form to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164-0024. You can also Fax your enrollment form to our company at 651-662-7258.
- If your employer has current group coverage and you are waiving (not applying for) coverage, give the enrollment form to your employer. Your employer should keep the enrollment form as evidence that you did not want coverage.

How to contact us

- 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 to people with disabilities or 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.

A Reason for enrolling

1. ☐ New employee ☐ New group ☐ Re-hire (re-hire date) _____ ☐ Open enrollment

   ☐ Waive coverage (not applying complete ONLY sections A, B, D, and G) ☐ Coverage change (details)_____

   ☐ Special enrollment (include supporting documents)

2. If your employer has current group coverage with Blue Cross, provide the **group and subgroup** numbers:

   Health Department Name and Number (if applicable)_____

__ __ __ __ __ - __ __
group subgroup

B Employee information

Name of Employer	Occupation or Duties	Classification ☐ Union ☐ Nonunion

Full-time Employment Date (mm/dd/yyyy)	Hours working per week	Preferred telephone number	Alternate telephone number

Employee First Name	Last Name	Social Security Number

Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Legal Marital Status: ☐ Single ☐ Married

Employee Home Address

Street City State Zip code

Email Address_____

C Dependent information - List ONLY dependents applying for coverage. Use Extra paper if necessary.

Name First	Last	Sex	Social Security Number	Relationship	Birth Date (mm/dd/yyyy)
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
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		☐ M ☐ F			
		☐ M ☐ F			

☐ Additional family members on attached page

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D Benefit selection

Your employer decides which benefits are available to employees. Employees must apply for coverage in order for dependents to receive coverage. If you are **not applying** for coverage, you must still complete this section and sign the enrollment form on page 5. Please check appropriate boxes.

HEALTH Applying for: ☐ Employee ☐ Spouse/Domestic Partner ☐ Children
Not Applying for: ☐ Employee ☐ Spouse/Domestic Partner ☐ Children

IF YOUR EMPLOYER OFFERS MULTIPLE HEALTH PLANS, WHICH HEALTH PLAN ARE YOU APPLYING FOR? _____
(Plan name)

If you are <u>not applying</u> for yourself or a family member, provide the reason: ☐ Spouse/Domestic Partner group coverage ☐ Individual coverage ☐ Group coverage continuation ☐ No other health coverage ☐ Medicare ☐ Medical Assistance ☐ General Assistance Medical Care ☐ TRICARE ☐ Other _____

Pediatric dental coverage is an essential health benefit. Pediatric dental coverage is available for purchase through a separate contract. For additional information on available pediatric dental plans, please visit www.mnsure.org.

E Current health coverage

1. Does any family member applying for our coverage currently have Blue Cross coverage? ☐ Yes ☐ No

If **Yes:**

Family Member Name	Identification Number

2. If you or any family member applying for this coverage is currently covered by Blue Cross, do you want that coverage canceled? ☐ Yes ☐ No If **Yes**, provide the individual name, identification number, group number, and cancellation date.

3. COORDINATION OF BENEFITS
Will you or any family member listed under this plan have other health or medical coverage once this policy is in force? ☐ Yes ☐ No

If the response is Yes, you may be contacted for more information.

4. MEDICARE INFORMATION

Are you or any dependent for whom you are applying for coverage covered by Medicare Part A (Hospital) and/or Part B (Medical)? ☐ Yes (complete section below) ☐ No

Employee: Effective Date Part A _____ Effective Date Part B _____ Medicare Claim Number _____ - ____ - _____ - ____

Eligibility Reason for Medicare: ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

Dependent: Effective Date Part A _____ Effective Date Part B _____

Medicare Claim Number _____ - ____ - _____ - _____

Eligibility Reason for Medicare: ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

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F Group Special Enrollment - Only complete this section if you are applying during a special enrollment.

Below is a list of common special enrollment triggering events. Check the event below, and/or add additional information regarding the reason for enrolling outside of open enrollment _____

Include required documents. If the required documentation is not received, you will be contacted.

If the event reason is: Newborn, Newborn grandchild, Marriage or Death of employee, complete the line below:

Date of Event or Birth | Full Name | County of event

Triggering Event	Required Documentation(s)	Notice Period
Acquiring a new dependent		
☐ Adoption / Placement of adoption / Placement for foster care	Court / Placement document(s)	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.
☐ Court ordered	Court document(s)	
☐ Newborn	Child's full name, date of birth and county	
☐ Newborn grandchild	Child's full name, date of birth and county and dependent grandchild form (X19246)	
☐ Marriage	Date and county of marriage	
Loss of Minimum Essential Coverage	**Confirmation of Loss of Coverage**	
☐ Death of employee	Name, date and county of death	Blue Cross must receive application within 30 days from the date of the triggering event
☐ Loss of eligibility for employee coverage	COBRA notice	
☐ Term employment or reduction in hours	COBRA notice	
☐ Plan no longer offers benefits	Letter from employer	
☐ Employer bankruptcy	Letter from employer	
☐ Legal separation/divorce	Court document(s)	
☐ Loss of dependent child status	Letter from previous carrier/court document(s)	
☐ Termination of all employer contributions	Letter from employer	
☐ COBRA exhaustion	Letter from previous carrier	
☐ Employee becomes entitled to Medicare (only if loss of coverage)	Medicare enrollment documentation	
Miscellaneous		
☐ Eligibility for/or loss of Premium Assistance through Medicaid or SCHIP	Letter from the State	Blue Cross must receive application within 60 days from the date of the triggering event

G Employee signature

Read this section, sign and date the enrollment form. You must sign this section even if you are not enrolling in any coverage. 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 enrollment form.

For the purposes of the enrollment form, 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 B of this enrollment form.

 (Continued on page 5)

G Employee signature - continued

In order to process this enrollment form, The Company may collect personal information regarding me or my family members listed on this enrollment form. 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 enrollment form. 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 enrollment form, 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 enrollment form in the decision whether to accept me and my family members listed on this enrollment form for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all required questions in the enrollment form, even if I and/or my family members listed on this enrollment form 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 enrollment form and the effective date of coverage. Failure to notify The Company of any change in the information contained on this enrollment form 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.

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 enrollment form and that any false information, omissions or misstatements on this enrollment form 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 enrollment form is completed as an electronic or online enrollment form, both parties agree to conduct this transaction electronically.

X	X
Signature Date	Employee Signature