An independent licensee of the Blue Cross and Blue Shield Association

A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name	First name	M.I.	Social Security Number	Home phone ( )

Employee's Home address	Street	City	State	Zip code	Work phone ( )

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (Circle)	Last name	First name	M.I.	Add/ Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #	Full-time Student
Self				☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Spouse				☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild				☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild				☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild				☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No

For full-time student list school: Anticipated graduation date:

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

☐ Elect or ☐ Waive Health (self)
☐ Elect or ☐ Waive Health (dependents)
☐ Elect or ☐ Waive Dental (self)
☐ Elect or ☐ Waive Dental (dependents)
☐ Elect or ☐ Waive Supplemental Life (Benefit chosen $________________)
☐ Elect or ☐ Waive STD
☐ Elect or ☐ Waive LTD
☐ Elect or ☐ Waive Life/AD&D (self)
☐ Elect or ☐ Waive Life/AD&D (dependents)

Health plan product name:	Dental plan product name:

If applying for life benefits, please indicate Beneficiary name and Relation to self:

Primary Beneficiary name ______________________________ Relation to self ______________________________

Contingent Beneficiary name ______________________________

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X

Signature of employee

Month Day Year

Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:

Monthly salary (Complete only if applying for salary based benefits) $ ____________________

Indicate the reason employee is enrolling for coverage:

☐ New employee
☐ Rehire (length of layoff) ___________
☐ New group
☐ Return from leave of absence (length of absence) ______________________________
☐ Previously waived coverage
☐ Change from part-time to full-time
☐ Certificate of coverage termination
☐ Other ______________________________

Date of event: ______________________________

Group numbers:

Health ______________ Dental ______________ Life ______________ STD ______________ LTD ______________

Department number ______________ Class ______________________________

I certify the above information to be true and correct.

Signature ______________________________ Date ______________________________

Employer name	Telephone number	Fax number

F8046R04 (10/06)

E. CURRENT AND PREVIOUS COVERAGE – **Failure to fully complete this section may result in a pre-existing condition limitation. Please attach copies of all certificates of prior coverage.**

Do you or any family member listed on this application, have any current health coverage or had previous health coverage within the last 63 days? ☐ Yes ☐ No If *YES* you must fully complete the following section

If you or any family member applying for this coverage is currently covered by Blue Cross and Blue Shield of Minnesota, Blue Plus, MII Life, Inc or Delta Dental, do you want that coverage canceled? ☐ Yes ☐ No

If YES, provide the individual's name, identification number, group number and cancellation date:

____

Starting with the employee, list each family member applying for our coverage and include information for all current and previous coverage in effect during the last 18 months. Make sure to include information for other Blue Cross and Blue Shield of Minnesota coverage:

Family Member Name	Insurance Company (name and policy number)	Date Coverage Started	Date Coverage Ended	Reason for Termination

F. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and 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

Spouse:

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

G. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C

Adding dependents: Date of event

☐ Birth/adoption ______

☐ Court order ______

☐ Marriage ______ County ______

☐ **Full-time student** **School** ______ **Anticipated graduation date** ______

☐ Other ______ Details ______

Cancelling dependents: Date of event

☐ Divorce ______

☐ Other (explain) ______

Loss of prior health and/or dental coverage:

Did you lose health coverage, dental coverage or both? ______

Date of event

☐ Other coverage voluntarily terminated ______

☐ Group continuation (COBRA) period exhausted ______

☐ Employer contribution for coverage terminated ______

☐ Coverage terminated due to loss of eligibility ______

☐ Address change

☐ Primary care clinic change

☐ Phone number change

☐ Name change

Previous ______
List new name in Section A

Reason ______

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

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