

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)

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

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

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

<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Health (self)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Supplemental Life (Benefit chosen \$ _____)
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Health (dependents)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive STD <input type="checkbox"/> Elect or <input type="checkbox"/> Waive LTD
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Dental (self)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Life/AD&D (self)
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Dental (dependents)	<input type="checkbox"/> Elect or <input type="checkbox"/> 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. 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:
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Monthly salary (Complete only if applying for salary based benefits) \$ _____

Indicate the reason employee is enrolling for coverage:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> New employee | <input type="checkbox"/> Rehire (length of layoff) _____ | <input type="checkbox"/> New group |
| <input type="checkbox"/> Return from leave of absence (length of absence) _____ | | |
| <input type="checkbox"/> Previously waived coverage | <input type="checkbox"/> Change from part-time to full-time | |
| <input type="checkbox"/> Certificate of coverage termination | <input type="checkbox"/> 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
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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