Application for Individual Dental/Vision Insurance

BlueCross BlueShield Minnesota

Please complete steps 1 – 8.

Step 1) Tell us about yourself.

Step 2) Tell us about your household.

Step 3) Choose a plan and payment.

Step 4) Tell us if you have other dental and/or vision insurance.

Step 5) Review notification and authorization information.

Step 6) Review payment and billing information.

Step 7) Sign the Application.

Step 8) Send your completed Application (all pages) and payment to Blue Cross and Blue Shield of Minnesota (Blue Cross).

If this Application is being completed by an agent/producer, please complete and return the Producer Attestation 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 or over the phone: Visit bluecrossmn.com/advisors to connect with a Blue Cross Advisor.
  If you work with an insurance agent/producer: Please contact your agent/producer 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.**

Who can enroll in the products on this Application?

- You must be a resident of Minnesota. You must obtain our Residency Policy at bluecrossmn.com/residencypolicy or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.
- If you are applying for new coverage as a contractholder, you must be over the age of 18. If you are under the age of 18, you must have a parent or guardian listed as the contractholder.
- 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.

Who can pay my Premium?

- Generally, you pay your own premium.
- 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, (e.g., cash, check, money order, credit card payment, electronic funds 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.

How do I submit this 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. All pages within this form must be returned to be considered a completed application.
- 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.
- To submit your Application faster, please use one of these options to enroll:
  – Email: enrollment.forms@bluecrossmn.com – Phone: 1-877-293-7040 – Online: bluecrossmn.com

STEP 1 - Tell us about yourself

I have an existing Blue Cross/Blue Plus® member ID number: ______________________________

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 or Vision individual plan:

☐ Adding a dependent ☐ Making a plan change

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

When you include Social Security numbers (SSNs), we can process your Application more efficiently, but you are not required to include them for your dependents or yourself.

First Name	Last Name and Suffix		
Social Security Number (If no SSN, write N/A)	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
Permanent Home Address (No P.O. Box #)			
City	State	ZIP	County
☐ Correspondence Address (If different from home address)			
City	State	ZIP	County
☐ Billing Address (If different from permanent home and correspondence address)			
City	State	ZIP	County
Email Address			
Home Telephone Number (Non-mobile)	Work Telephone Number	Mobile Telephone Number	

1. I have been a permanent resident of Minnesota for a minimum of 183 days: ☐ Yes ☐ No
   Important: We can only offer coverage to permanent Minnesota residents.
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 an **ineligible** third party described on page 1? ☐ Yes ☐ No

GO TO STEP 2

STEP 2 - Who will be on the Plan?

Tell us about everyone who is applying for coverage.

Dependent 1	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐Yes ☐ No **If No,** list address:				

Dependent 2	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

Dependent 3	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

Dependent 4	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

Dependent 5	Relationship to you	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

Dependent 6	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

Dependent 7	Relationship to You	Date of Birth (mm/dd/yyyy)	Social Security Number (optional)	Gender
First Name				☐ Male ☐ Female
Last Name				
Does this dependent live at the same address as you? ☐ Yes ☐ No **If No,** list address:				

☐ Additional dependent(s) on attached page.

GO TO STEP 3

STEP 3 - Coverage and payment selection

Your coverage will begin on the first day of the month following receipt of your completed Application unless you indicate a different requested effective date below – whichever is later. Requested effective dates must be within 90 days following receipt of your completed Application.

Dental Coverage Option: Freedom ☐ $1,500 ☐ $2,000 ☐ Value Standard ☐ Value Enhanced ☐ Value Premium ☐ Preferred Bill Frequency Options: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual Premium Payment ($): ____________	My coverage will be for: ☐ Contractholder only ☐ Contractholder and one dependent ☐ Family	Requested Effective Date: ________________________ (mm/yyyy) If adding a child dependent outside of renewal, check the reason for the add: ☐ Newborn ☐ Newborn grandchild ☐ Adoption/placement for adoption ☐ Court ordered
Vision Coverage Option: ☐ Value Standard – with Exam ☐ Value – Eyewear Only Plan Annual Premium Payment (Annual Billing Only) ($): ________________	My coverage will be for: ☐ Contractholder only ☐ Contractholder and one dependent ☐ Family	Requested Effective Date: ________________________ (mm/yyyy) If adding a child dependent outside of renewal, check the reason for the add: ☐ Newborn ☐ Newborn grandchild ☐ Adoption/placement for adoption ☐ Court ordered

STEP 4 Dental and/or Vision insurance information

If you have a current Blue Cross Individual/Family dental and/or vision policy, your current plan 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 a dental plan under this Application had continuous comparable coverage immediately prior to the effective date of the dental plan selected in STEP 3? If you answered Yes, please provide the supporting documents listed below and complete question 2. **NOTE:** Previous dental coverage will be reviewed and may impact your eligibility or benefits. Supporting document(s) must be provided to prove eligibility. Discount dental coverage does not qualify as comparable coverage. **Supporting Documentation:** • Letter for previous dental carrier showing comparable coverage - Must be on the official carrier letterhead - Must list all persons covered under the plan and their coverage dates • Summary of plan benefits	☐ Yes ☐ No

2.	**Carrier:**	**Effective Date:**	**Cancel Date:**	**Contractholder:**

☐ Additional coverage information on attached page.

REMITTANCE SLIP A separate check/payment is required for each dental and vision plan.

Please complete the form below.

Contractholder Name (First, Last): ____

Telephone Number: __________________ ZIP: ______________ 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 or email 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	**Applicant's First Name**

GO TO STEP 5

STEP 5 - Notification and authorization information

By completing this enrollment Application, I understand that I will be submitting an actual request for enrollment and I agree to the following:

- My signature on this Application indicates that I 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 4. 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 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.
- 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 dependents 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 claims, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- By providing an email address, I agree to receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates. I may unsubscribe or change my email address at any time by following the instructions included in each email communication.
- By providing a telephone number, I expressly consent to accept and receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Cross and its affiliates, via text message or voice call to my mobile device and to the cellular/mobile telephone number(s) that I provided.

  NOTE: Email 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 email or text message from an unsecured email or device, Blue Plus does not accept liability for any errors or omissions in the contents of the email or text message, which arise as a result of email 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 dependents enrollment eligibility and coverage of benefits under this dental or vision coverage may be subject to a lock-out period. Dental coverage may also be subject to a waiting period. I understand and agree Blue Cross will act in reliance upon the information I have provided on this Application, which materially affects enrollment eligibility and may result in the denial of claims, 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.

Attention: This page must be included when returning your completed application.

GO TO STEP 6

STEP 6 - Payment and billing information

- For dental coverage, you can pay your dental plan 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.
- For vision coverage, you must pay your vision plan 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.

STEP 7 - Sign Application

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

Applicant's Signature ____ Date ________________

STEP 8 - Send your completed Application and payment

Send in your completed Application and payment to Blue Cross by one of the following methods.

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 982806
El Paso, TX 79998

Fax or email:

Fax your completed, signed Application to (651) 662-6439 or email to enrollment.forms@bluecrossmn.com. Then 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

Important: Your enrollment may be delayed if this Application is not completed in its entirety.
Please fill out and return all pages of this application.

For Producer Use Only

PRODUCER ATTESTATION

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, you will not be assigned as the AOR.

Blue Cross Agency Code (10-digit code)	Producer Code (10-digit code)

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

I attest I have reviewed the completed Application with the Applicant(s) and:

- 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 and Blue Plus contract. Note: Visit Agent Central and search for "Agent Code of Conduct."
- I am not aware, based on the Applicant's responses to my inquiries, of any factors impacting the eligibility of the Applicant and each of his or her dependents applying for coverage
- I further understand that no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy, or waive any contractual rights or requirements
- I attest the Applicant was present and signed this Application in my presence
- I provided a copy of the submitted Application to the Applicant(s), in its entirety, immediately in a secure manner pursuant to all applicable laws
- I agree to retain a copy of the submitted Application for my records and to provide a copy of the submitted Application to Blue Plus upon request.

Agency Name ____________________

Producer Name ____________________
First MI Last

Producer Signature ____________________ Date __________

Business Telephone ____________________

Producer Email ____________________

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

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

INTERNAL USE ONLY

Blue Cross Agency Code (10-digit code)	Producer Code (10-digit code)

BlueCross BlueShield Minnesota

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

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, တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTY အဂီၢ်, ကိး 711 တက့ၢ်.

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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