2024 Enrollment/Waiver Form

☐ **Enrolling**
(Complete sections I, II, IV, and V.)
☐ **Waiving**
(Complete sections I and III.)
☐ **Information Changes**
(Complete sections I and II.)

For cancellations, use form F8708.

I Employee/Contractholder Information (Must be completed for both enrollees and waivers.)

Effective Date	Employer/Group Name	Group Number	Payroll Location/Dept. #

First Name	MI	Last Name	Occupation

Address

City	State	ZIP	County	Phone Number

Email address	Social Security Number (if no SSN, write N/A)*

Marital Status (Please check one.):	Enrollment Status	
☐ Single/Widowed	☐ Active Employee	☐ Employment Change From Part-Time to Full-Time
☐ Married	☐ Rehired Employee	☐ COBRA Continuant Start Date _____ / _____ /_________________
		☐ Special Enrollment Event ____________________Date___/___/___

Full-Time Hire (or Rehire) Date (mm/dd/yyyy) / /	Hours Worked per Week	Primary Care Clinic # (if applicable)

Sex	Date of Birth (mm/dd/yyyy)	Age	Product Selection(s) (if your employer offers these coverage options):
☐ Male	/ /		☐ Medical Plan Number: ___________________
☐ Female			☐ Dental Product Name: ___________________
			☐ Vision Product Name: ___________________

II Dependent Information (If enrolling more than four dependents, please attach a separate sheet.)

Spouse / Domestic Partner

First Name	MI	Last Name	Relationship to You? ☐ Spouse ☐ Domestic Partner

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Primary Care Clinic # (if applicable)

Dependent #1

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Step-child ☐ Adopted** ☐ Other**

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

Dependent #2

First Name	MI	Last Name	Relationship to You ☐ Child ☐ Step-child ☐ Adopted** ☐ Other**

Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Age

Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled	Primary Care Clinic # (if applicable)

*Social Security numbers (SSN) for you and your dependents are requested but not required.
** If enrolling an adopted child or a child who has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

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

Dependent #3				
First Name	MI	Last Name	Relationship to You ☐ Child ☐ Step-child ☐ Adopted** ☐ Other**	
Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female		Date of Birth (mm/dd/yyyy) / /	Age
Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled		Primary Care Clinic # (if applicable)	

Dependent #4				
First Name	MI	Last Name	Relationship to You ☐ Child ☐ Step-child ☐ Adopted** ☐ Other**	
Social Security Number (if no SSN, write N/A)*	Sex ☐ Male ☐ Female		Date of Birth (mm/dd/yyyy) / /	Age
Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	Dependent Status if Age 26 or Older: ☐ Disabled		Primary Care Clinic # (if applicable)	

☐ **Additional family members on attached page**

*Social Security numbers (SSN) for you and your dependents are requested but not required.
** If enrolling an adopted child or a child who has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is available for medical plans only to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and the Uniform Glossary are accessible at bluecrossmn.com or available free of charge when requested by contacting your employer or your employer's agent or broker, or by calling customer service toll free at 1-800-382-2000.

III Waiver of Coverage (ONLY complete this section if you are declining coverage offered to you and/or your family members.)

Medical (if your employer offers this coverage)

I hereby decline medical coverage:
☐ For myself
☐ For family members ONLY
☐ For myself and ALL family members
☐ For the following family members:
____
____

Reason for declining medical coverage:
☐ Other spouse/domestic partner group medical coverage
☐ Other parent group medical coverage
☐ Individual coverage
☐ Group coverage continuation
☐ No other health coverage
☐ Medicare ☐ Medical Assistance
☐ General Assistance Medical Care
☐ TRICARE/VA ☐ Other: ___________________

Dental (if your employer offers this coverage)

I hereby decline dental coverage:
☐ For myself
☐ For family members ONLY
☐ For myself and ALL family members
☐ For the following family members:
____
____

Vision (if your employer offers this coverage)

I hereby decline vision coverage:
☐ For myself
☐ For family members ONLY
☐ For myself and ALL family members
☐ For the following family members:
____
____

I hereby acknowledge that I have been given the opportunity to participate in the group medical, dental, and/or vision plans provided by my employer. If I and/or any of my eligible dependents desire to apply for this coverage at a later date, I may be required to wait until my group's renewal or until a special enrollment event occurs before coverage will be offered.

III Waiver of Coverage – Continued

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, 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. (For dental and/or vision coverage **only**, you may also enroll an eligible dependent under age 3 anytime up to 30 days following the child's third birthday.) 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.

Employee/Contractholder Signature - **Only sign here if you are waiving coverage** Date

IV Other Health (Medical) Insurance Coverage

Other Group or Non Group Health (Medical) Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			☐ Active ☐ Retired Date of Retirement: ___/___/_____

Medicare Coverage (Please list any family member who is eligible for Medicare benefits.)

Name of Subscriber or Dependent	Health (Medical) Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End-Stage Renal Disease	
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No

V Important: Authorized Signature Required

Read this section and sign and date the Application. Blue Cross and Blue Shield of Minnesota and Blue Plus hereinafter referred to as Blue Cross, will act in reliance on the information you provide on this Application.

For the purposes of the Application, 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 I of this Application.

In order to process this Application, Blue Cross may collect personal information regarding me or my family members listed on this Application. The information collected by Blue Cross or Blue Cross'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 Blue Cross and to correct personal information Blue Cross has collected about me or my family members listed on this Application. Upon my request, Blue Cross will furnish a more detailed notice of Blue Cross information practices. Blue Cross 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 Application, 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, Blue Cross 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.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept me and my family members listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all required questions in the Application, even if I and/or my family members listed on this Application currently have coverage or had prior coverage with Blue Cross.

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.

V Important: Authorized Signature Required – Continued

I understand that neither the medical plan nor the dental plan includes coverage for the pediatric dental essential health benefit and that Blue Cross has made me aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit mnsure.org.

I agree to notify Blue Cross immediately of any change in my or my family members 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 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.

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 pecuniary interests. "Payments" include those made by any means (e.g., cash, check, money order, credit card payment, electronic fund transfer). 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 Blue Cross.

I acknowledge that I am not applying for this coverage in connection with any offer from any ineligible third party to pay any premium or cost sharing related to this plan.

I understand that the health plan I have selected may contain a limited number of providers in the network listed on my application, the providers in the network may change from time to time, and not every provider is in network for my plan. I also understand and acknowledge that with limited exceptions if I visit a provider or a location that is not in-network, I will pay more for my care, and these costs will count towards any applicable out-of-network cost sharing (e.g., the out-of-network deductible and out-of-pocket [limitation/maximum]). Refer to the member benefit booklet for additional information.

I understand and agree that Blue Cross may share my past, current and future health and account records with my network providers about services I've received from my network providers and non network providers. These records may be used by my network providers as needed to manage or coordinate my care and to improve the quality of that care.

By providing my email address, I agree to receive communications and/or 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 my phone number, I expressly consent to accept and receive communications and or 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.

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 Blue Cross will act in reliance upon the information I have provided on this Application and that any false information, omissions or misstatements on this Application that materially affect enrollment eligibility may result in the denial of a claim(s) and/or a premium adjustment. I also understand and agree Blue Cross may rescind the contract if Blue Cross determines that (1) I performed an act, practice, or omission that constitutes fraud, and/or (2) I made an intentional misrepresentation or omission of material fact.

WARNING: 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 Cross does not accept liability for any errors or omissions in the contents of this message, which arise as a result of email or text message transmission.

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

______________________________	______________________________
Print Employee/Contractholder Name	Print Employer/Group Name
______________________________	______________________________
Employee/Contractholder Signature	Date

- Please contact your employer or your employer's producer for assistance.
- Call 1-800-382-2000 (toll free) to request this information in other languages and formats. For TTY, call 711. Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

Submission Instructions - Employees: Please return your completed form to your employer.
Employers: Completed employee forms should be returned to Blue Cross

- **New Group Business:** Please refer to your agent or benefits administrator.
- **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 (during the 30 day period before the annual renewal date) and
- **Ongoing Enrollment:** Adding new employees/contractholders/or dependents to an existing group.

Please submit on the employer portal or via fax: (651) 662-7258), email Enrollment.Forms@bluecrossmn.com, or mail to: Blue Cross and Blue Shield of Minnesota / P.O. Box 982806 / El Paso, TX 79998-2806

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.

image_0006_NDL_Portrait (09/16)

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.

နမ့ၢ်ကတိၤကညီကျိာ်ဒီး, 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.

image_0002R02_General_Portrait (01/17)