

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

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

Health plan product name: _____ Dental plan product name: _____

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE. Signature of employee _____ 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 () ()
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E. CURRENT AND PREVIOUS COVERAGE – Failure to fully complete this section may result in a preexisting 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, USABLE Life, Mill Life, Inc., or Delta Dental of Minnesota, do you want that coverage canceled? Yes No
If YES, provide the individual's name, identification number, company name, group number and cancellation date:

Starting with the employee, list each family member applying for 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: Use additional sheet if necessary.

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

F. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage?
 Yes No

If yes, you must complete the following: (Medicare: List both Part A and B effective dates)

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (Single or Family)	Effective date

If Medicare: check reason for entitlement: Age Disability End-Stage Renal Disease
 Disability & Current End-Stage Renal Disease

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

Adding dependents: Date of event Cancelling dependents: Date of event

Birth/adoption _____ Divorce _____

Court order _____ Other (explain) _____

Marriage _____ County _____

Full-time student School _____ Anticipated graduation date _____

Other _____ Details _____

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

Delta Dental of Minnesota is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their dental products.
USABLE Life is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their life and disability products.