

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 () ()
Employee's Email address					

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 #
Self					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			

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 Dental (self)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive LTD
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Dental (dependents)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Life/AD&D (self)
	<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:
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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.

<input checked="" type="checkbox"/> Signature of employee	Date signed <small>Month Day Year</small>
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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"/> Change from part-time to full-time	
<input type="checkbox"/> Previously waived coverage	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Certificate of coverage termination		

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, MII 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
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (explain)	_____
<input type="checkbox"/> Marriage	_____	County _____	
<input type="checkbox"/> Other	_____	Details _____	

Loss of prior health and/or dental coverage:

Did you lose health coverage, dental coverage or both? _____
 Date of event _____

<input type="checkbox"/> Other coverage voluntarily terminated	_____	<input type="checkbox"/> Address change	
<input type="checkbox"/> Group continuation (COBRA) period exhausted	_____	<input type="checkbox"/> Primary care clinic change	
<input type="checkbox"/> Employer contribution for coverage terminated	_____	<input type="checkbox"/> Phone number change	
<input type="checkbox"/> Coverage terminated due to loss of eligibility	_____	<input type="checkbox"/> 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.