

E. 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 (for 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 End-stage Renal Disease

F. COVERAGE CHANGE INFORMATION -- CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTIONS 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 in details):	_____
<input type="checkbox"/> Marriage	_____	County: _____	
<input type="checkbox"/> Other	_____	Details: _____	

Loss of prior health and/or dental coverage:
 Did you lose health coverage?: Yes No

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

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