BlueCross BlueShield Minnesota

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 (check)	Last name	First name	M.I.	Cancel Eff. Date	Add/ Cancel	Sex	Marital Status	Social Security #	Birth Date (Mo. Day Yr.)
☐ Self					☐ Add ☐ Cancel	☐ M ☐ F	☐ Married ☐ Single		
☐ Spouse					☐ Add ☐ Cancel	☐ M ☐ F	☐ Married ☐ Single		
☐ Child Stepchild					☐ Add ☐ Cancel	☐ M ☐ F	☐ Married ☐ Single		
☐ Child Stepchild					☐ Add ☐ Cancel	☐ M ☐ F	☐ Married ☐ Single		
☐ Child Stepchild					☐ Add ☐ Cancel	☐ M ☐ F	☐ Married ☐ Single		

C. BENEFIT SELECTION -- CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

☐ Elect or ☐ Waive Health (self)

☐ Elect or ☐ Waive Health (dependents)

Health plan product name:

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X _____
Signature of employee

Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee's date of employment (MM/DD/YY):	Employee's 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 group #: _____ Health subgroup #: _____ Department #: _____

I certify the above information to be true and correct.

Signature: _____ Date: _____

Employer name:	Telephone number	Fax number

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

☐ Birth/adoption _____
☐ Court order _____
☐ Marriage _____ County: _____
☐ Other _____ Details: _____

Cancelling dependents: Date of event

☐ Divorce _____
☐ Other (explain in details): _____

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

Date of event

☐ Other coverage voluntarily terminated _____
☐ Group continuation (COBRA) period exhausted _____
☐ Employer contribution for coverage terminated _____
☐ Coverage terminated due to loss of eligibility _____ Reason: _____

☐ Address change
☐ Phone number change
☐ Name change

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