BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

USAble Life

MII Life
An independent licensee of the Blue Cross and Blue Shield Association

DELTA DENTAL
DELTA DENTAL OF 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
					( )

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					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Spouse					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single				☐ Yes ☐ No

For full-time student list school: **Anticipated graduation date:**

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

☐ Elect or ☐ Waive Health (self)
☐ Elect or ☐ Waive Health (dependents)
☐ Elect or ☐ Waive Dental (self)
☐ Elect or ☐ Waive Dental (dependents)
☐ Elect or ☐ Waive Supplemental Life (Benefit chosen $_____)
☐ Elect or ☐ Waive STD
☐ Elect or ☐ Waive LTD
☐ Elect or ☐ Waive Life/AD&D (self)
☐ Elect or ☐ 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.

X _____ Signature of employee

Month / Day / Year — 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
	( )	( )

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

- ☐ Birth/adoption _____
- ☐ Court order _____
- ☐ Marriage _____ County _____
- ☐ **Full-time student** **School** _____ **Anticipated graduation date** _____
- ☐ Other _____ Details _____

Cancelling dependents: Date of event

- ☐ Divorce _____
- ☐ Other (explain) _____

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.