BlueCross BlueShield Nebraska

Blue Cross and Blue Shield of Nebraska
PO Box 3248
Omaha, Nebraska 68180-0001

Group Health and Dental Enrollment Form (With Multiple Plan Options)

Instructions:
1. Be sure to complete all questions in full. Incomplete forms cause unnecessary delays.
2. If you need more space for any answers, you may attach a separate piece of paper. Please include your name and Social Security number on any attachments.
3. Please print legibly in black pen.

☐ New Application (Complete all sections except Section C. Complete Section H, if applicable.)

☐ Change (Complete all sections except Section B. Complete Section H, if applicable.)

Section A. Applicant Information

Social Security Number	Name (Last) (First) (MI) (Title)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

Address (Street, PO Box) (City) (State) (ZIP+4 Code) (County)

Home Phone Number	Work Phone Number	Cell Phone Number	Email Address	Marital Status: ☐ Single ☐ Married ☐ Divorced

Account Name (Employer or Organization)	Account Number	Subaccount Number

Job Title	Date Employed with Group	Hours Worked per Week	Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? If Yes, please give name(s) & ID number(s). ☐ Yes ☐ No

Are you or your spouse terminating other Blue Cross and Blue Shield coverage? If Yes, please complete Section E. Loss of Coverage ☐ Yes ☐ No

Are you a member of a federally-recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

Section B. Health and Dental Election(s) for Newly Eligible Employees

I hereby apply for:

HEALTH PLAN OPTION
(Not all options may be available to you under your Plan)
Select one and indicate Deductible:
☐ PPO Option..... $ _____
☐ High Deductible (HSA-eligible) Option $ _____

☐ **HEALTH**
☐ Employee only
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ _____

(If applicable to your plan)
☐ **DENTAL**
☐ Employee only
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ _____

(If applicable)
☐ **MEDICARE SUPPLEMENT**
Only available to active employees or spouses age 65 and older when the group has fewer than 20 full and/or part-time employees.

(If Applicable To Your Plan)
HEALTH NETWORK OPTION (Not all options may be available to you under your Plan)
Select Network Option:
☐ NEtwork BLUE
☐ Premier Select BlueChoice
☐ Blueprint Health
☐ Other - Network Name: _____

Section C. Coverage Change Election(s) For Current Members

I hereby apply for the following changes in coverage: ☐ **Health Only** ☐ **Dental Only** ☐ **Both**

☐ Change To: ☐ Employee only Coverage ☐ Family Coverage ☐ Employee and Spouse Coverage ☐ Employee and Child(ren) Coverage

Change Reason: ☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Other: _____ Date: _____

☐ Add New Dependent(s): _____ Date Dependent(s) joined your household: _____ (Complete Section D.)
_____ Date Dependent(s) joined your household: _____ (Complete Section D.)

☐ Change Network Options (if applicable) ☐ NEtwork BLUE ☐ Blueprint Health ☐ Premier Select BlueChoice ☐ Other - Network Name: _____

☐ Other Changes: _____
_____

Section D. Personal Data

List below spouse and other dependent(s) to be covered including eligible children under age 26. List In Order of Age – Oldest First.

Full Name (Last, First, MI)	Social Security Number	Date of Birth (MM/DD/YYYY)	M	F	Relation to Employee
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Name (Last)	(First)	(MI)	Social Security Number

Section E. Loss of Coverage - Special Enrollment

Are You or Dependent terminating (or losing) other health coverage? ☐ Yes ☐ No If YES, please complete the following:

1) Give us the reason for loss of other health coverage:

☐ Employment terminated ☐ Death, divorce, or legal separation ☐ I/we voluntarily chose to drop other insurance

☐ Spouse employment terminated ☐ I/we have reached the end of COBRA coverage ☐ Other: _____

2) Coverage termination date: _____

3) Please provide the notice of termination, or loss of eligibility documentation from the other insurance company.

Section F. Medicare Secondary Payor Information

Are you, your spouse, or dependent(s) enrolled in Medicare? ☐ Yes ☐ No If the answer is "Yes," please fill in requested information below:

If Medicare: Name of Beneficiary _____

Medicare HIC #: _____

Part A effective date: _____

Part B effective date: _____

Reason for entitlement (check all applicable boxes): ☐ Age ☐ Disability ☐ End stage renal disease

Section G. Acknowledgement and Authorization

I confirm that my answers and statements in this enrollment form are true and complete to the best of my knowledge and belief. I understand that any intentional misrepresentation in this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

By providing your telephone number(s) and email address, you agree that we, along with our affiliates and/or vendors, may email you and call or text any phone number(s) provided, including a wireless number, using an automatic telephone dialing system and/or prerecorded message. Without limit, these calls and email messages may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

If you wish to opt out of electronic/automatic telephonic messages, please contact Member services department at 402-390-1820 or 888-592-8961.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage ends due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.
Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information contact our Member Services department at 402-390-1820 or toll free 888-592-8961.

Signature of Applicant: _____ Date: _____

Section H. Declination Of Coverage. Complete only if you elect not to participate in the group insurance offered.

The group health/dental program has been offered to me and after seriously considering its benefits, I choose:

☐ not to enroll myself in the health/dental plan.

☐ not to enroll myself and my dependents in the health/dental plan.

☐ not to enroll my dependents in the health/dental plan.

Coverage in the health/dental plan is declined because:

☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's health coverage.
My spouse is employed by (name of firm) _____

☐ I am enrolled and/or ☐ My dependents are enrolled, under a COBRA continuation or state continuation coverage.

☐ I have and/or ☐ My dependents have, individual coverage through ☐ Medicare ☐ Medicaid ☐ SCHIP ☐ another insurance company

☐ Other reason(s) _____

If you decline enrollment for yourself and your dependents, a request for enrollment at a later date may be subject to late enrollment restrictions. See "Special Enrollment Notice" above.

Signature of Applicant: _____ Date: _____