BlueCross BlueShield of Nebraska

P.O. Box 3248 • Omaha, Nebraska 68180-0001

An Independent Licensee of the Blue Cross and Blue Shield Association.

SignatureBlue Enrollment Form

FOR INTERNAL USE
Group Number _____
Group Department _____

☐ New Group ☐ New Hire ☐ Change

Please print and complete all sections of this enrollment form with black ballpoint pen. Be sure to complete all questions in full. Incomplete enrollment forms cause unnecessary delays. If you need more space for any answers, you can use a separate piece of paper. Please include your name and social security number. Complete Section B, if applicable.

Section A. APPLICANT INFORMATION

Social Security Number	Name (Last) (First) (M.I.) (Title)			Sex ☐ M ☐ F
Date of Birth (mmddyyyy)	Home Phone Number ( )	Work Phone Number ( )	Cell Phone Number ( )	Marital Status: ☐ Single ☐ Married ☐ Divorced

Address (Street, P.O. Box, Apt. #) (City) (State) (Zip+4 Code) (County)

E-mail Address

Group Name (Employer or Organization)	Date employed w/Group (mmddyyyy)	Work Hrs./wk.

Are you, your spouse or dependent/s current or former Blue Cross and Blue Shield insureds or applicants? ☐ Yes ☐ No If yes, list name(s) & ID number/s.

Are you, your spouse or dependent/s terminating other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No If yes, list reason and date (mmddyyyy):

Section B. DECLINATION OF COVERAGE. Complete only if you elect not to participate in the group insurance offered.

The group dental program has been offered to me and after seriously considering its benefits, I have decided:

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

Coverage in the dental plan is declined because:

- ☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's 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) _____

Signature of Applicant: _____ Date: _____

Section C. DENTAL ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES.

I HEREBY APPLY FOR: ☐ One Person ☐ Family ☐ Employee and Spouse ☐ Employee and Child(ren)

Section D. PERSONAL DATA

List below spouse and other dependent(s) to be covered including eligible dependent children under age 26. List in order of age – oldest first.

Full Name (Last, First, M.I.)	Social Security Number	Date of Birth (mmddyyyy)	Sex M	Sex F	Relation to Employee

Applicant's Name (Last)	(First)	(M.I.)	(Title)	Social Security Number

Section E. COVERAGE CHANGE ELECTION(S) FOR CURRENT MEMBERS

I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE:

☐ CHANGE TO: ☐ One Person Coverage ☐ Employee and Child(ren) Coverage ☐ Family Coverage ☐ Employee and Spouse 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.)

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

☐ Other Changes: _____

_____

Section F.

I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on 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.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health/dental insurance or group health/dental 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 30 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 30 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 terminates 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 1-800-642-8980.

Signature of Applicant: _____ Date: _____