

BlueFreedom Employee Enrollment Form

For Internal Use
Account No. _____
SubAccount No. _____

PO Box 3248 • Omaha, Nebraska 68180-0001

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. **If declining coverage, please complete section H.**

Section A. Applicant Information

Social Security Number	Name (Last)	(First)	(MI)	(Title)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male
						<input type="checkbox"/> Female
Address (Street, PO Box)		(City)	(State)	(Zip+4 Code)	(County)	
Home Phone Number	Work Phone Number	Cell Phone Number	Email Address		Marital Status:	
						<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Account/Group Name (Employer or Organization)				Account/Group Number	Subaccount/Roll 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). <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you or your spouse terminating other Blue Cross and Blue Shield coverage? If Yes, please complete Section E. Loss of Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you a member of a federally-recognized American Indian or Alaska Native tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Section B. Health And Dental Election(s) For Newly Eligible Employees

I Hereby Apply For:

<input type="checkbox"/> HEALTH <input type="checkbox"/> One Person <input type="checkbox"/> Family <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> If Dual Option Group Please indicate deductible \$ _____ <input type="checkbox"/> If High Deductible Health Plan, Select One: <input type="checkbox"/> Health Savings Account (HSA) (Please complete Form 37-044, if applicable) <input type="checkbox"/> No Account Set-Up Required	<input type="checkbox"/> DENTAL <input type="checkbox"/> One Person <input type="checkbox"/> Family <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren)	<input type="checkbox"/> MEDICARE SUPPLEMENT (Not available to active employees or their spouses age 65 and older unless the group has fewer than 20 full and/or part-time employees.)
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(If Applicable To Your Plan)
 NETWORK OPTION (not all options may be available to you under your Plan)
 Network BLUE
 Premier Select BlueChoice
 Blueprint Health
 Other - Network Name: _____

Within the past six months, have you or any dependents used tobacco products four or more times a week? Yes No

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

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

Other Health Changes: _____

Within the past six months, have you or any dependents used tobacco products four or more times a week? Yes No

Name (Last)	(First)	(MI)	(Title)	Social Security Number
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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, MI)	Height	Weight	Social Security Number	Date of Birth (MMDDYYYY)	M	F	Relation to Employee
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	

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. Health History

Answer each question YES or NO. For conditions answered "Yes," give details below.
This information is necessary for rating purposes. Your enrollment for health coverage will not be declined based on answers to these questions, or any health status-related factors. You should not disclose genetic information (including family history). If you are a new hire or changing your coverage, you are not required to complete this section. To request a copy of our Privacy Policy, contact us in Omaha 402-390-1820 or toll free 800-642-8980.

1. In the past 5 years, have you or any of your dependents been tested, diagnosed or treated (including prescription medication usage) or been advised to seek treatment for:
 1. Alcohol or drug abuse..... Yes No
 2. Arthritis, Bone, Joint, Spine, Muscle or Connective Tissue Disorder..... Yes No
 3. Autoimmune disease, including Crohn's disease, Lupus or Multiple Sclerosis..... Yes No
 4. Cancers, tumors or polyps..... Yes No
 5. Circulatory, blood or heart disorders including high blood pressure..... Yes No
 6. Cirrhosis, hepatitis or any other disease of the liver..... Yes No
 7. Cystic Fibrosis or Rheumatic Fever..... Yes No
 8. Digestive disorders including any conditions of the colon, esophagus, gallbladder, intestines, pancreas or stomach.... Yes No
 9. Diabetes, hyperthyroidism, hypothyroidism or any endocrine disorder or disease..... Yes No
 10. Manifested genetic or developmental disorders including use of growth hormones..... Yes No
 11. HIV / AIDS or any other immune system disorder..... Yes No
 12. Infertility or any other reproduction system disorder..... Yes No
 13. Lung disease or disorder..... Yes No
 14. Neurological disorders including Alzheimer's, Cerebral Palsy, Epilepsy, migraines, Parkinson's or seizures..... Yes No
 15. Organ transplant..... Yes No
 16. Paralysis including paraplegia and quadriplegia..... Yes No
 17. Vascular disorders including stroke, CVA or TIA..... Yes No
2. In the past 5 years, have you or any of your dependents been hospitalized, had surgery or plan to have surgery for any illness, injury or condition or is anyone currently pregnant?..... Yes No
3. In the past year, have you or any of your dependents incurred medical or pharmacy expenses in excess of \$5,000?..... Yes No

For any "Yes" answers identified above, please provide complete details below. Attach a separate piece of paper if necessary.

Question Number	Person	Condition	Treatment Performed or Recommended	Degree of Recovery

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 have decided:

- not to enroll myself in the health plan.
- not to enroll myself in the dental plan.
- not to enroll myself and my dependents in the health plan.
- not to enroll myself and my dependents in the dental plan.
- not to enroll my dependents in the health plan.
- not to enroll my dependents in the 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 my spouse's dental coverage.
- I am enrolled and/or My dependents are enrolled, under a COBRA continuation coverage or state continuation coverage.
- I have and/or My dependents have, individual coverage through Medicare Medicaid SCHIP another insurance company
- Other reason(s) _____

Name (Last)	(First)	(MI)	(Title)	Social Security Number
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Section I. Acknowledgement and Authorizations

I represent 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 numbers you agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless number, using an automatic telephone dialing system and/or prerecorded message. Without limit, these calls may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

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 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 888-592-8961.

Signature of Applicant: _____ Date: _____