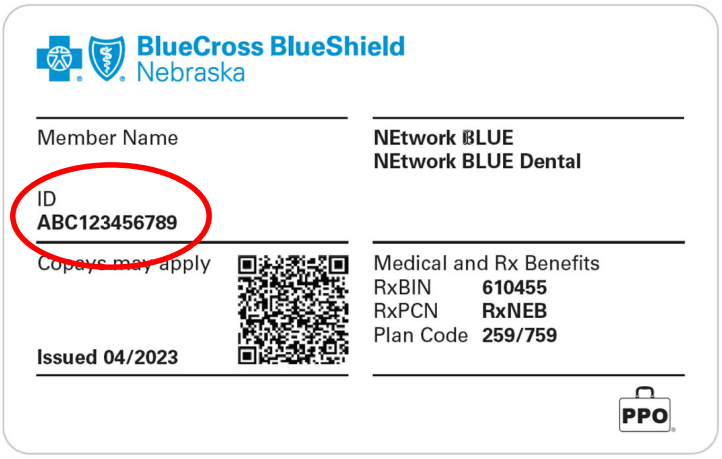
# Instructions for Completing the EHA Direct Bill Health and Dental Enrollment Form

1. **Check the "New Application"** box under the Blue Cross and Blue Shield of Nebraska (BCBSNE) logo.


2. **APPLICANT INFORMATION:**

   - Select your membership category. If you (or your spouse) are not an Administrator or Board Member, please select "Employee/Spouse."


   - Complete all the requested information, including the school district and school name you or your spouse are leaving and your BCBSNE member ID number (found on the front of your ID card).
   - Note: Please have your spouse list your school district on their application.

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3. **Premium Payment Information:** Indicate your monthly payment preference on the form. Your payment options are:

    - **Monthly Direct Bill:** If you want to be billed for your premium and send us a check each month, select “Monthly Direct Bill.” **Please do not send your payment with your enrollment form. You will receive a bill showing when your first month’s payment is due.**

    - **Monthly Bank Debit:** If you want your payments automatically withdrawn from your checking or savings account each month, select “Monthly Bank Debit.” For checking account withdrawals, include a **voided** check with the form. For savings account withdrawals, please provide a letter from your financial institution on their letterhead, including the routing number, account number and a bank official's signature, verifying the account can be used for the monthly premium withdrawal. **Automatic withdrawal of your premium will occur on or after the 15th of each month.**

4. **Health and Dental Election(s) for Newly Eligible Persons:** Indicate the class of coverage requested for both medical and dental options and then select your health deductible plan.

Note: Dental coverage is mandatory for the subscriber (employee). Your dependents may elect medical only, dental only, or both medical and dental; **only if they had medical and/or dental coverage under your active EHA policy.**

5. **Personal Data:** List the dependent family members that will be covered on your Direct Bill plan.

6. **Current Insurance Information:** Please list any other health coverage that will be in effect while you are enrolled in your Direct Bill plan (including Medicare).

7. **Sign and date the form** at the bottom.

8. Please email the form and an image of your voided check to: **DirectBill@NebraskaBlue.com** or you can mail the form and voided check to:

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