BlueCross BlueShield Nebraska

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

Group Health Enrollment Form

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 using 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 Election(s) for Newly Eligible Employees

I hereby apply for HEALTH:

- ☐ Employee only
- ☐ Family
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)
- ☐ _____

(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:

(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.

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

I hereby apply for the following changes in coverage:

☐ 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
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

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.

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

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 toll free 844-201-0763.

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 844-201-0763.

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 program has been offered to me and after seriously considering its benefits, I choose:

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

Coverage in the health 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 (if requested other than during a special enrollment period). See "Special Enrollment Notice" above.

Signature of Applicant: _____ Date: _____

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Spanish (Mexico)
ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi
توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)
ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese
ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen
ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါအံၤ ဘဉ်သ့ဉ်သ့ဉ် ကအိဉ်ဒီးတ်ဂ့ၢ်တၢ်ကျိၤလၢ အရူဒိဉ်ဘဉ်ယး နလံာ်ပတံထိဉ်တၢ် မ့တမ့ၢ် တၢ်အ့ဉ်ကီၤသးန့ဉ်လီၤ.
ကွၢ်ယု မ့ၢ်နံၤမ့ၢ်သိအရူဒိဉ်လၢ လံာ်ဘိးဘဉ်သ့ဉ်ညါအံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့ၢ်ဝိလၢ မ့ၢ်နံၤလၢခံကတၢ်လၢ တၢ်ဟ်ပနီဉ်နှၤ်နၤ လၢနကဟ့ဉ်နတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ဘူးတၢ်လဲတဖဉ် မ့တမ့ၢ် မၤန့ၢ်တၢ်မၤစၢၤလၢ တၢ်ပူၤလိၤလဲတဖဉ်နှဉ်လီၤ.
နၤ မ့တမ့ၢ် ပှၤတဂၤဂၤလၢ နမၤစၢၤမ့ၢ်အိဉ်ဒီးတ်သံကွၢ်အဃိ. နအိဉ်ဒီးတ်ခွဲးတ်ယာ်လၢ ကမၤန့ၢ်တ်မၤစၢၤဒီးတ်ဂ့ၢ်တ်ကျိၤလၢ နကျိာ်လၢ တလၫ်ဘူဉ်လာ်စ့ၤဘဉ်နှဉ်လီၤ.
လၢနကကတိၤတ်ဒိး ပှၤကျိးထံတ်အဂိၢ်. ကိး1-800-991-5840.တက့ၢ်.

Korean
주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish
ئاگاداری
ڕەنگە ئەم ئاگادارییە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواربەرەکییەکانی ناو ئەم ئاگادارییە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێرێک، پەیوەندی بە 18009915840 بکە.

Lao
ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານການເງິນປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali
ध्यानाकर्षण: यो सूचनामा तपाईको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

Oromo
HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian
ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese
CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.