



Extension of Coverage Request for Extended Eligibility to Age 30 Group Plans

Nebraska law allows a dependent who ceases to be a full-time student or attains an age exceeding the specified age at which coverage ceases pursuant to the plan, to continue coverage through the end of the month in which the dependent: (a) marries; (b) ceases to be a resident of the state, unless the child is under 19 years of age or is enrolled on a full-time basis in any college, university or trade school; (c) receives coverage under another health benefit plan or self-funded employee benefit plan; or (d) attains 30 years of age. The subscriber will be billed an additional premium for such coverage equivalent to that of a single adult.

This form must be completed and returned to Blue Cross and Blue Shield of Nebraska no later than 31 days after the date in which the dependent would otherwise lose coverage under the plan.

SECTION I

Name of Subscriber: _____

Address of Subscriber: _____

Identification Number: _____

Name of Dependent: _____

Dependent's Date of Birth (Mo., Day, Year): _____

Address of Dependent: _____

Is the dependent named above married: Yes No

If yes, provide the date of marriage: _____

Is the dependent named above a resident of Nebraska: Yes No

If no, provide the date the dependent moved from Nebraska : _____

Does the dependent named above have other health insurance coverage: Yes No

If yes, provide the date coverage was effective: _____

SECTION II Acknowledgment & Signature

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 understand that my premium will be increased in an amount equivalent to a single adult premium, and that I must pay my employer for this coverage. I authorize my employer to deduct from my earnings any required premiums.

Signature of Subscriber: _____

Date: _____

PLEASE NOTIFY YOUR EMPLOYER REGARDING YOUR INTENTION TO MAINTAIN COVERAGE FOR YOUR DEPENDENT

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 أستلة، 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 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 ۱-۸۰۰-۹۹۱-۵۸۴۰ 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

ကုလာ မှန်စောင့်သို့အရနိုင်လဲ ထိုတိုးဘင်္ဂသိန်္ခိုက်ပါကြော်တက်၏

ဘုရားသည် နကာပါ ဟောပိုဒ်တွင် မြန်မာစာတွင် အမြန် ဖြစ်ပါသည်။

၈၁နက်

Korean

주의: 본고지에는 해당 신청서 또는 적용 범위에 대한 중요한 정보가 있을 수 있습니다.
본고지의 주요 날짜를 찾으십시오. 해당 건강 보험을 유지하거나 비용을 지원받는 특정 기한 까지 조치를 취하셔야 합니다. 본인 자신이나 다른 인이 돋고 있는 누군가가 질문이 있다면 무료로 모국어로 된 도움 과정 정보를 얻을 수 있는 권리가 있습니다. 통역사와 통화하려면 1-800-221-1212 으로 문의하세요.

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Lao

ສືບຕິພາບໂຄງການໃຈສັນເກົ່າ ລາຍລະອຽດທີ່ມີສຳຄັນຢ່າງເປົ້າຫຼາຍ

จ้าวอนุทราวัน เผื่องร้อนสำหรับเด็กๆ ที่ต้องการดูแลสุขภาพเด็กๆ ให้ดีที่สุด

ເພື່ອຮັກສາການຄົນຄອງດັນສະຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັກການຂວຍເຫຼືອທາງດ້ານງິປະມານ. ຖ້າທ່ານກ່າວທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄໍາຖາມ, ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເມື່ອ 1-800-991-5840.

Nepali

દ્વાયાનાકર્ષણ: યો સુચનામા તપાઈકો નિવેદન વા કભેરેજો બારેમા મહત્વપર્ણ જાનકારી હનસક્છા. યો સુચનામા મુખ્ય મિતિહરૂ હેન્હોસુ. તપાઈકો સ્વાસ્થ્ય કભેરેજ વા લાગતમા મદદત પ્રાપ્ત ગર્ન તપાઈલે નિશ્ચિત સમયસૌમા ભિત્ત કરબાહી લિનુંપર્ણ હનસક્છા. તપાઈ વા તપાઈલે સહાયતા ગરેકા કસેસંગ જિ જાસાહરુ છન ભને તપાઈસંગ આપનો ભાષામા નિઃશુલ્ક સહાયતા ર જાનકારી પ્રાપ્ત ગર્ને અધીકાર છ. દોભાષેસંગ કુરા ગર્ન 1-800-991-5840.મા કલ ગર્નહોસુ.

Oromo

HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyata 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 lakkofsa 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.