BlueCross BlueShield of Nebraska

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

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

BluePride
Employee Enrollment Form

FOR INTERNAL USE
Group No. _____
Group Dept. _____

☐ 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)	Ht. (ft. in.) ' "	Wt. (lbs.)	Home Phone Number ( )	Work Phone Number ( )	Cell Phone Number ( )	Marital ☐ Single ☐ Divorced

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

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

- ☐ not to enroll myself in the health/dental plan.
- ☐ not to enroll myself and my dependents in the health/dental plan.
- ☐ not to enroll my dependents in the health/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 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. HEALTH AND DENTAL ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES.

I HEREBY APPLY FOR:

☐ HEALTH
- ☐ One Person
- ☐ Family
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)

If Dual Option Group –

Please indicate deductible

$ _____

If High Deductible Health Plan – Select One
- ☐ Health Savings Account (HSA) (Please complete form 37-044, if applicable)
- ☐ No Account Set-Up Required

☐ DENTAL
- ☐ One Person
- ☐ Family
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)

☐ MEDICARE SUPPLEMENTAL

(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.)

Name (Last)	(First)	(M.I.)	Social Security Number

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)	Height (ft. in.)	Weight (lbs.)	Sex M	Sex F	Relation to Employee

Section E. 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 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 Health Changes: _____

_____

Section F. HEALTH HISTORY

ANSWER EACH QUESTION YES or NO. For conditions answered "YES," give details below.
This information is necessary for rating and reinsurance review purposes for health insurance and for underwriting of life coverage, if applicable. Your application 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 are 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.

The following questions pertain to YOU AND ANY ELIGIBLE DEPENDENTS APPLYING FOR COVERAGE.

1. Are you or any of your dependents currently pregnant? Due Date _____ ☐ Yes ☐ No
2. Are you or any of your dependents currently ill or taking any medications? ☐ Yes ☐ No
3. Within the past twelve months, have you or any dependents used tobacco products? ☐ Yes ☐ No
4. Within the last 5 years, have you or any of your dependents:
   a. Consulted or been examined, advised or treated by any doctor, chiropractor, counselor, therapist or other medical practitioner? ☐ Yes ☐ No
   b. Been hospitalized or undergone any medical testing or treatment? ☐ Yes ☐ No
   c. Been advised of the need for any future treatment or surgery? ☐ Yes ☐ No
   d. Been diagnosed or received treatment for cancer; heart, liver, kidney, or lung disease; alcohol or drug abuse; diabetes; back, spine, or joint problems; nervous or mental problems; seizures; stroke; stomach, intestinal, or esophagus problems? ☐ Yes ☐ No
   e. Been convicted of a DWI offense or had a drug or alcohol evaluation? ☐ Yes ☐ No

   If yes to question 4e, please give details, including dates: _____

   _____

   Was there a finding of alcohol or drug dependency? ☐ Yes ☐ No

   If yes, give date of last use of alcohol (or drugs, if applicable). MM/YYYY: _____

For any "YES" answers identified above, please provide complete details on the next page. Attach a separate piece of paper if necessary.

Name (Last)	(First)	(M.I.)	Social Security Number

Section F. HEALTH HISTORY (continued)

Medical Questionnaires may be requested when more information is necessary on certain conditions:

Question	Name of Person	Name of Condition (Diagnosis)	Dates Seen (From - To)	Describe Treatment Details, Surgery, etc.	Estimated # of Health Care Visits Over the Past 2 Years	Degree of Recovery

List the names of any medications taken in the past 24 months and the reason for taking them.

Name of Person	Name of Medication	Reason	Date First Prescribed	Date of Last Use

Section G.

If any of these conditions are present, please answer the applicable question(s):

1) Seizures or Epilepsy: Give date of last seizure. Identify type of seizures: Name_____ Date _____
☐ Petit Mal ☐ Grand Mal ☐ Other _____ Name_____ Date _____

2) High Cholesterol: Give the most recent cholesterol level and date taken. Name_____ Level _____ Date _____

Name_____ Level _____ Date _____

3) Diabetes: Give the most recent hemoglobin A1C level or fasting blood sugar and date taken. Name_____ Level _____ Date _____

Name_____ Level _____ Date _____

Section H.

I represent that my answers and statements in this application are true and complete to the best of my knowledge and belief. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for this review. I authorize my employer to deduct from my earnings any required premiums. I understand that coverage is not in force unless or until my employer enters into a contract with Blue Cross and Blue Shield of Nebraska.

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 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.

Name (Last)	(First)	(M.I.)	Social Security Number

Section H. (continued)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Description and Purpose of Authorization – I authorize any health care provider, pharmacy and pharmacy related service organizations, to release my protected health information (PHI) to Blue Cross and Blue Shield of Nebraska (BCBSNE) for the purpose of determining premium rates and medical rating of the group.

I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcriber hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. I understand that my PHI may include information relating to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug abuse).

I authorize BCBSNE or its reinsurer to make a brief report of my protected health information to MIB, Inc.

Terms and Conditions of Authorization – I understand I may revoke this authorization in writing at any time. Revocation of this authorization will not affect any action taken by BCBSNE in reliance on this authorization. Unless revoked earlier, this authorization will expire upon an offer of coverage from BCBSNE.

I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be protected by federal regulations governing the privacy of health information.

Signature of Applicant:_____ Date: _____