BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive • P.O. Box 3248
Omaha, Nebraska 68180-0001

Group Health Enrollment Form

Instructions: 1. Complete the enrollment form with black pen. Be sure to complete all questions in full. Incomplete forms cause unnecessary delays.
2. If you need more space for any answers, you can use a separate piece of paper. Please include your name and social security number.
3. **Please Print** 4. **White (original/top page) - BlueCross BlueShield of NE; Green (back/copy page) - Contract**

☐ **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) (M.I.) (Title)	Date of Birth (Mo., Day, Year)	☐ Male ☐ Female

Address (Street, P.O. Box) (City) (State) (Zip+4 Code) (County)	Telephone Number ( )	Marital Status ☐ Single ☐ Married ☐ Divorced

Group Name (Employer or Organization)	Group Number	Job Title	Date employed with Group	No. of hours worked per week

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? ☐ Yes ☐ No If Yes, please give name(s) & ID number(s).	Are you or spouse terminating other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No If Yes, please give reason and date:

Are you a member of a federally-recognized American Indian or Alaska Native tribe? ☐ Y ☐ N

Section B. HEALTH ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES

I HEREBY APPLY FOR HEALTH

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

Section C. HEALTH CHANGE ELECTION(S) FOR CURRENT MEMBERS

I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE:

☐ Change to One Person Health ☐ Change to Employee and Child(ren) Health
☐ Change to Family Health ☐ Change to Employee and Spouse Health
Change Reason: ☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Other Date: _____
☐ Add New Dependent(s): Date Dependent(s) joined your household _____ (Complete Section D.)
☐ Other Health Changes: _____

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 (Mo., Day, Year)	(X) Sex M	(X) Sex F	Relation to Employee

Section E. PRIOR INSURANCE INFORMATION

ARE YOU LOSING OTHER HEALTH COVERAGE?
IF YES, THE FOLLOWING INFORMATION WILL HELP YOU AVOID DELAYS IN CLAIM PAYMENTS:

1) List all the plans that insured you and your dependent(s) within the last 24 months:

Previous Insurance Company	Address of Previous Insurance Company	Telephone Number of Previous Insurance Company	Policy Number	Effective Date	Termination Date

2) Attach the "CERTIFICATE OF CREDITABLE COVERAGE" from your previous insurer.
If you haven't received this form, contact the insurance company and ask for one.

3) Name(s) and telephone number(s) of the prior employer(s) who provided health coverage:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

4) Reason you have lost other coverage:

☐ I quit my job ☐ Death, divorce, or legal separation ☐ I/we voluntarily chose to drop other insurance
☐ Spouse quit his/her job ☐ I/we have reached the end of COBRA coverage ☐ Other: _____

Name (Last)	(First)	(M.I.)	(Title)	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.

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 an intentional 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 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.

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 1-800-642-8980.

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 have decided:

- ☐ 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 "Notice" above.

Signature of Applicant: _____ Date: _____