



**A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2**

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone ( )
Employee's Home address	Street	City	State	Zip code	Work phone ( )
Employee's Email address					

**B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)**

Relation (Circle)	Last name	First name	M.I.	Cancel Eff. Date	Add/Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #	Full-time Student
Self					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single				<input type="checkbox"/> Yes <input type="checkbox"/> No

For full-time student list school: \_\_\_\_\_ Anticipated graduation date: \_\_\_\_\_

**C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE**

<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Health (self)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Supplemental Life (Benefit chosen \$ _____)
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Health (dependents)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive STD <input type="checkbox"/> Elect or <input type="checkbox"/> Waive LTD
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Dental (self)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Life/AD&D (self)
<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Dental (dependents)	<input type="checkbox"/> Elect or <input type="checkbox"/> Waive Life/AD&D (self with dependent life coverage)
Health plan product name: _____	Dental plan product name: _____

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.  Signature of employee \_\_\_\_\_ Date signed \_\_\_\_\_

**D. THIS PART TO BE COMPLETED BY EMPLOYER**

Employee date of employment (MM/DD/YY): _____	Employee occupation: _____	Hours worked per week: _____
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Monthly salary (Complete only if applying for salary-based benefits) \$ \_\_\_\_\_

Indicate the reason employee is enrolling for coverage:

New employee  Rehire (length of layoff) \_\_\_\_\_  New group

Return from leave of absence (length of absence) \_\_\_\_\_

Previously waived coverage  Change from part-time to full-time

Certificate of coverage termination  Other \_\_\_\_\_

Date of event: \_\_\_\_\_

Group numbers:  
 Health \_\_\_\_\_ Dental \_\_\_\_\_ Life \_\_\_\_\_ STD \_\_\_\_\_ LTD \_\_\_\_\_  
 Department number \_\_\_\_\_ Class \_\_\_\_\_

I certify the above information to be true and correct.  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer name	Telephone number ( )	Fax number ( )
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**E. CURRENT AND PREVIOUS COVERAGE** — Failure to fully complete this section may result in a preexisting condition limitation. Please attach copies of all certificates of prior coverage.

Do you or any family member listed on this application, have any current health coverage or had previous health coverage within the last 63 days?  Yes  No If YES you must fully complete the following section

If you or any family member applying for this coverage is currently covered by Blue Cross and Blue Shield of Minnesota, Blue Plus, USABLE Life, MII Life, Inc., or Delta Dental of Minnesota, do you want that coverage canceled?  Yes  No  
If YES, provide the individual's name, identification number, company name, group number and cancellation date:

**Starting with the employee, list each family member applying for coverage and include information for all current and previous coverage in effect during the last 18 months.** Make sure to include information for other Blue Cross and Blue Shield of Minnesota coverage: Use additional sheet if necessary.

Family Member Name	Insurance Company (name and policy number)	Date Coverage Started	Date Coverage Ended	Reason for Termination

**F. MEDICARE AND OTHER COVERAGE INFORMATION**

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage?  Yes  No

If yes, you must complete the following: (Medicare: List both Part A and B effective dates)

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (Single or Family)	Effective date

If Medicare: check reason for entitlement:  Age  Disability  End-Stage Renal Disease  
 Disability & Current End-Stage Renal Disease

**G. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C**

<b>Adding dependents:</b>	Date of event _____	<b>Cancelling dependents:</b>	Date of event _____
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (explain)	_____
<input type="checkbox"/> Marriage	_____ County _____		
<input type="checkbox"/> Full-time student	School _____	<b>Anticipated graduation date</b>	_____
<input type="checkbox"/> Other	Details _____		

**Loss of prior health and/or dental coverage:**

Did you lose health coverage, dental coverage or both? \_\_\_\_\_  
Date of event \_\_\_\_\_

Other coverage voluntarily terminated \_\_\_\_\_  
 Group continuation (COBRA) period exhausted \_\_\_\_\_  
 Employer contribution for coverage terminated \_\_\_\_\_  
 Coverage terminated due to loss of eligibility \_\_\_\_\_

Address change  
 Primary care clinic change  
 Phone number change  
 Name change

Previous \_\_\_\_\_  
List new name in Section A

Reason \_\_\_\_\_

**ENROLLMENT CHANGE FORM SHOULD BE SENT TO:** Blue Cross and Blue Shield of Minnesota and Blue Plus  
P.O. Box 64024  
St. Paul, Minnesota  
55164-0024

Delta Dental of Minnesota is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their dental products.  
USABLE Life is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their life and disability products.