



A. SMALL GROUP EMPLOYEE APPLICATION AND CHANGE FORM – **Read Instructions for Application on Page 4.**
Please print all information in black or blue ink.

If your employer has current group coverage with our company, provide the **group and subgroup** numbers:

_____ - _____ - _____ - _____ - _____
Health Dental Life Short Term Disability Long Term Disability
(group and subgroup)

Name of Employer _____ Occupation or Duties _____

Full-time Employment Date _____ Hours working per week _____ Work phone _____ Home phone _____
/ / () ()

Employee's First Name _____ M.I. _____ Last Name _____ Social Security Number _____
/ /

Date of Birth _____ Sex _____ Height _____ Weight _____ Primary Care Clinic Number (PCC#)
/ / / Male Female (Required for Blue Plus):

Marital Status
 Single Married If married, Date of Marriage: ____/____/____ County and State of Marriage: _____/____

Employee's _____ Street _____ City _____ State _____ Zip code _____
Home Address

B. DEPENDENT INFORMATION – List all dependents applying for coverage. Use extra paper if necessary

Name	Sex	Social Security #	Relation (Circle)	Birth Date (Mo. Day Yr.)	Height	Weight	PCC#	Full-time Student (Age 19+)
First M.I. Last								
	M / F		Spouse	/ /				_____
	M / F		Child Stepchild	/ /				School Grad. Date _____
	M / F		Child Stepchild	/ /				School Grad. Date _____
	M / F		Child Stepchild	/ /				School Grad. Date _____
	M / F		Child Stepchild	/ /				School Grad. Date _____

C. BENEFIT SELECTION – Your employer decides which benefits are available to employees.

Employees must apply for coverage in order for their dependents to receive coverage.

If you are not applying for coverage, you must still complete this section and sign the application on page 4.

1. Benefit Selection (select the benefits you want and identify which family members are applying or not applying for coverage):

A. Health Applying for: Employee Spouse Children **Not Applying for:** Employee Spouse Children

If you are **not applying** for yourself or a family member, provide the reason: Spouse's group coverage Individual coverage
 Group coverage continuation No other health coverage Medicare Medical Assistance General Assistance Medical Care
 MCHA (effective date of MCHA coverage _____) Other _____

If your employer offers two health plans, which health plan are you applying for? _____

B. Dental Applying for: Employee Spouse Children **Not Applying for:** Employee Spouse Children

If you are **not applying** for yourself or a family member, provide the reason: Other dental coverage No other dental coverage

C. Employee Life/AD&D Applying Not Applying **D. Dependent Life** Applying Not Applying

E. Short Term Disability Applying Not Applying **F. Long Term Disability** Applying Not Applying

Complete if applying for employee life and/or disability benefits: Annual Salary \$ _____

Beneficiary Name _____ Relation to Employee _____

If you decide to apply for health coverage at a later date, you and/or your dependents may be subject to an 18-month preexisting condition limitation period. You give up your option for dental benefits if you do not apply for dental coverage when you are first eligible.

D. COVERAGE CHANGE INFORMATION

1. Adding dependents:

Birth/Adoption Date of Event / /

Court Order / /

Full-time Student / /

Marriage / /

Other / /

2. Deleting dependents:

Divorce Date / /

Other (explain) Date / /

County _____

Details _____

3. Loss of prior health and/or dental coverage:

What coverage did you lose? Health Dental Health and Dental

Other coverage voluntarily terminated Date of Event / /

Group continuation (COBRA) period exhausted / /

Employer contribution for coverage terminated / /

Coverage terminated due to loss of eligibility / /

Reason _____

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.

Important Note: This coverage does not provide benefits for a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date, until the coverage has been active for at least 12 consecutive months, or for late entrants, 18 consecutive months. Credit will be given for prior continuous qualifying coverage to reduce the preexisting condition limitation period.

1. Do you, or any family member listed on this application, have current health coverage or had previous health coverage within the last 18 months? Yes No If **Yes**, you must fully complete the following section.

Starting with the employee, list each family member applying for our 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:

Family Member Name	Insurance Company (name and policy number)	Date Coverage Started	Date Coverage Ended (if still active, state "active")	Reason for Termination of Coverage
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

2. If you or any family member applying for this coverage is currently covered by Blue Cross Blue Shield of Minnesota, Blue Plus, MII Life, Inc. or Delta Dental, do you want that coverage canceled? Yes No

If **Yes**, provide the individual's name, identification number, group number, and cancellation date.

F. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? **Yes (complete section below)** No

Employee: Effective Date Part A ____/____/____ Effective Date Part B ____/____/____ Medicare Claim Number ____ - ____ - ____ - ____

Eligibility Reason for Medicare: Age Disability End-Stage Renal Disease Disability & End-Stage Renal Disease

Spouse: Effective Date Part A ____/____/____ Effective Date Part B ____/____/____ Medicare Claim Number ____ - ____ - ____ - ____

Eligibility Reason for Medicare: Age Disability End-Stage Renal Disease Disability & End-Stage Renal Disease

G. MEDICAL INFORMATION – You do not have to disclose a test to detect the presence of human immune deficiency virus (HIV), or other bloodborne pathogens which was administered to you at the time you were: (1) a criminal offender or a crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; (4) patients or employees of a secured facility. The term emergency medical personnel includes individuals employed to provide out of hospital medical emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service who provide emergency medical services; a member of an organized first responder squad that is formally recognized by a political subdivision in Minnesota; crime lab personnel; other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law; and any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure.

- 1. Have you or any family member included on this application ever been treated for or diagnosed for any of the following conditions** (Circle the condition and check each item YES or NO):
- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| A. Heart, blood, circulatory system disorders, including stroke, high blood pressure, or heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Digestive or intestinal disorders, including ulcers, hernia, hepatitis, gallbladder or liver disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Kidney or urinary tract disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Male or female reproductive system disorders, including prostate gland, infertility, or menstrual disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Breast disorders, including complications from breast implants | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Respiratory system disorders, including emphysema, asthma and allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Endocrine disorders, including diabetes, thyroid, pancreas, or pituitary gland disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Psychological disorders, including attention deficit, behavioral, or eating disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Neurological or neuromuscular disorders, including multiple sclerosis, cerebral palsy, or seizure disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Muscle, bone, joint or back disorders, including scoliosis, arthritis, or temporomandibular joint disorder (TMJ) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Cancer, tumor or polyp | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Eye, ear, nose, or throat disorders, including cataracts, ear infections, and hearing impairments | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Immune system disorder or positive test results, including AIDS, lupus and scleroderma | <input type="checkbox"/> | <input type="checkbox"/> |

- 2. Please answer the following questions for you and all family members included on this application:**
- | | | |
|---|--------------------------|--------------------------|
| A. Has any applicant had any surgery or hospitalizations during the past five (5) years? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Is any applicant currently taking or taken any prescribed medication during the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Does anyone have back or neck pain, joint or muscle pain, headaches, stomach or abdominal pain, chest pain, shortness of breath, dizziness or fainting episodes, fever or swollen glands, or an injury for which a physician has not yet been consulted? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Is any applicant currently pregnant? If Yes , list the due date and describe any complications experienced or if multiple births are expected in #5 | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Has any applicant used tobacco or smokeless tobacco during the past 12 months? If Yes , provide details on the product, duration and frequency of use in #5 | <input type="checkbox"/> | <input type="checkbox"/> |

- 3. Indicate if you or any family member included on this application in the past five (5) years have:**
- | | | |
|--|--------------------------|--------------------------|
| A. Ever used drugs regularly, other than drugs prescribed by an attending physician, or been treated for the use of drugs or alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been convicted of DWI or any other alcohol related incident; or had his/her driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Ever been advised by a health care professional to quit or reduce the use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |

- 4. Have you or any family member been covered by Minnesota Comprehensive Health Association (MCHA)?**
If **Yes**, provide names of all covered individuals, dates of coverage, and qualifying health risk in #5.

5. Provide full details for all "Yes" answers above. Use extra paper if necessary. Please print all information in black or blue ink.

Question # & Letter	Person's Name	Diagnosis or Details about Condition, Treatment, Medication	Date of Onset	Date of Recovery	Days in Hospital	Doctor or Clinic Name

**H. EMPLOYEE REPRESENTATION – Read this section, sign and date the application.
You must sign this section even if you are not applying for any coverage.**

I have read the statements and answers on this application and declare them to be true and complete. I understand and agree that Blue Cross and Blue Shield of Minnesota, Blue Plus, MII Life, Inc., and Delta Dental, hereinafter referred to as the company, will act in reliance on the information provided on this application and that any misstatements on this application which materially affect either the acceptance of risk or hazard assumed by the company may result in denial of claims or cancellation of the coverage. I also agree to notify the company in writing of any change in any family member's health condition between the date this application is completed and the effective date of coverage. Any changes occurring during this time period should be described in a letter signed by the employee and mailed to the company at the address listed at the bottom of this page. Failure to notify the company of any change in health history between the date this application is completed and the effective date of coverage may result in denial of claims or cancellation of the coverage. If there is a misstatement in the application or if there is a failure to provide updated health information, the company cannot use the misstatement to cancel coverage that has been in effect for two (2) or more years. This time limit does not apply to fraudulent misstatements. The fraudulent misstatement provision only applies to health contracts. I also understand and agree that the payment of a claim does not preclude the right of the company to deny future claims or take any action it determines appropriate.

The health coverage does not provide benefits for a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date, until the coverage has been active for at least 12 consecutive months, or for late entrants, 18 consecutive months. Credit will be given for prior continuous qualifying coverage to reduce the preexisting condition limitation period. Please provide details of all other health coverage in Section E.

For the purposes of the application, the employee understands and agrees that 'employee' is defined as only those individuals subject to FICA and other tax withholding, and performing services for compensation for the employer listed in Section A of this application.

Upon request, I agree to furnish any additional information needed concerning the eligibility of any dependent.

X _____ X _____
Signature Date Employee's Signature

I. APPLICATION INSTRUCTIONS – Please print all information in black or blue ink.

New Groups applying for coverage:

1. If you are applying for coverage, fully complete all sections except Section D.
2. If you are not applying for any coverage, you only need to fully complete Section A, Section C, and Section H.
3. If applying for Blue Plus health coverage, make sure to list a Primary Care Clinic (PCC#) for yourself (Section A) and dependents (Section B).
4. Give the completed application to the Agent or BCBSM Sales Representative.

Existing Groups adding or changing employee/dependent coverage:

1. If you are applying for coverage, fully complete all sections.
2. In order to avoid delays in the processing of your application you must provide the correct Group and Subgroup numbers (ask your employer for these numbers) and the complete Employer Name in Section A.
3. Make sure you provide complete information in Section E. Failure to provide complete information about your prior health coverage can affect the preexisting condition limitation.
4. If your employer offers two (2) health plans, make sure you indicate the health plan you want in Section C (#1A).
5. If applying for Blue Plus health coverage, make sure to list a Primary Care Clinic (PCC#) for yourself (Section A) and dependents (Section B).
6. Mail the completed application to BCBSM, P.O. Box 64024, St. Paul, MN 55164-0024.
7. If you are not applying for any coverage, you only need to fully complete Section A, Section C, and Section H. Your employer should keep this application as evidence that you did not want coverage.

**Review your application to make sure you have provided all required information.
An incomplete application can result in a delay in the processing of your application.**