BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

DELTA DENTAL

DELTA DENTAL OF MINNESOTA

USAble Life

Small Group Employee Application and Change Form

Applying for coverage

- Fully complete all sections in black or blue ink.
- New Groups or New Employees: You do not need to complete section E.
- Existing Groups: In order to avoid delays in the processing of your application you must provide the correct Group and Subgroup numbers in section A (ask your employer for these numbers). You must also provide the complete Employer Name in section B.
- If applying for Blue Plus health coverage, make sure to list a Primary Care Clinic (PCC#) for yourself (section B) and dependents (section C).
- If your employer offers two (2) health plans, make sure you provide the name of the health plan you want in section D.
- Important: Make sure you provide complete information in section F. Failure to provide complete information about your prior health coverage can affect the preexisting condition limitation and may result in nonpayment of claims.

Changing your coverage (adding or deleting dependents)

- If you are adding dependents, fully complete all sections.
- If you are deleting dependents, fully complete sections A, B, E, and H.
- Important: Make sure you provide complete information in section F. Failure to provide complete information about your prior health coverage can affect the preexisting condition limitation and may result in nonpayment of claims.
- If applying for Blue Plus health coverage, make sure to list a Primary Care Clinic (PCC#) for yourself (section B) and dependents (section C).

Waive coverage (not applying)

- If you are not applying for any coverage, you only need to fully complete sections A, B, D, and H.

Submission instructions

- If your employer is applying as a new group with Blue Cross and Blue Shield of Minnesota (Blue Cross), give the completed application (even if you are waiving all coverage) to the Agent or Blue Cross Sales Representative.
- If your employer has current group coverage with Blue Cross and you are applying for coverage or changing your coverage, mail the completed application to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164-0024.
- If your employer has current group coverage and you are waiving (not applying) for coverage, give the application to your employer. Your employer should keep the application as evidence that you did not want coverage.

How to contact us

- Please contact your Agent for assistance or call 651-662-5035 or 1-888-878-0138 and one of our Blue Cross representatives will be happy to assist you.

A Reason for application

☐ New employee ☐ New group ☐ Late enrollment (previously waived coverage) ☐ Add dependents
☐ Re-hire (re-hire date) _____ ☐ Cancel coverage (complete ONLY sections A, B, E and H)
☐ Waive coverage (not applying complete ONLY sections A, B, D, and H) ☐ Coverage change (details) _____

If you or any family members applying for this coverage currently have Blue Cross and Blue Shield of Minnesota (Blue Cross) coverage, please provide the identification number(s): _____

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 - subgroup)	__ __ __ __ __ - __ __ (group - subgroup)	__ __ __ __ __ - __ __ (group - subgroup)	__ __ __ __ __ - __ __ (group - subgroup)	__ __ __ __ __ - __ __ (group - subgroup)

B Employer and employee information

Name of Employer	Occupation or Duties	Classification ☐ Union ☐ Nonunion

Full-time Employment Date (mm/dd/yyyy)	Hours working per week	Preferred telephone number ( )	Alternate telephone number ( )

Employee First Name Last Name	Social Security Number

Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Height	Weight	Legal Marital Status: ☐ Single ☐ Married

Employee Home Address
Street City State Zip code

Email Address _____ (Required for Blue Plus) **Primary Care Clinic Name and Number (PCC#):** _____

C Dependent information - List ONLY dependents applying for coverage. Use Extra paper if necessary.

Name First	Last	Sex	Social Security Number	Relationship	Birth Date (mm/dd/yyyy)	Height	Weight	PCC#
		M / F						
		M / F						
		M / F						
		M / F						
		M / F						

☐ Additional family members on attached page

D Benefit selection

Your employer decides which benefits are available to employees. Employees must apply for coverage in order for dependents to receive coverage. If you are **not applying** for coverage, you must still complete this section and sign the application on page 6. Please check appropriate boxes.

HEALTH Applying for: ☐ Employee ☐ Spouse ☐ Children Not Applying for: ☐ Employee ☐ Spouse ☐ Children

If you are <u>not applying</u> for yourself or a family member, provide the reason: ☐ Spouse 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 (2) HEALTH PLANS, WHICH HEALTH PLAN ARE YOU APPLYING FOR?_____

 (Continued on page 3)

DELTA DENTAL - Delta Dental is an independent dental insurance company that does not provide Blue Cross products or services. Delta Dental is solely responsible for the dental coverage.

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

USABLE LIFE - USAble Life is an independent life insurance company that does not provide Blue Cross products or services. USAble Life is solely responsible for the life, AD&D and disability coverage.

A. Employee Life/AD&D ☐ Applying ☐ Not Applying B. Dependent Life ☐ Applying ☐ Not Applying
C. Short-Term Disability ☐ Applying ☐ Not Applying D. Long-Term Disability ☐ Applying ☐ Not Applying

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

Life Insurance Beneficiary Designation - This will revoke any existing beneficiary designation you may have.

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

E Coverage change information

1. Adding dependents: Date of Event (mm/dd/yyyy)
   - ☐ Adoption _____
   - ☐ Birth _____
   - ☐ Court Order _____
   - ☐ Marriage _____
   - ☐ Other _____ Details _____

2. Deleting dependents:
   - Dependent names: _____
   - ☐ Divorce Date _____
   - ☐ Other (explain) Date _____

3. Loss of prior health and/or dental coverage:
   What coverage did you lose? ☐ Health ☐ Dental ☐ Health and Dental Date you lost your coverage: _____
   Why did you lose your coverage?
   - ☐ You and your family lost coverage on another plan due to: ☐ Spouse left employment ☐ retirement ☐ divorce ☐ death ☐ reduction in hours, or lay-off
   - ☐ Your continuation of coverage (COBRA) from a previous group has reached the maximum time allowed.
   - ☐ Other - please explain: _____

F Current / previous health coverage - The preexisting condition limitation does not apply to any insured member under age 19.

Failure to fully complete this section may result in a preexisting condition limitation which may result in nonpayment of claims. Please include 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 at least 12 consecutive months, or for late entrants, 18 consecutive months following the enrollment date. **Credit will be given for prior continuous qualifying creditable 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 question 2.
2. 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 coverage:

Family Member Name	Insurance Company Name and Policy Number (Include Blue Cross coverage)	Date Coverage Started (mm/dd/yyyy)	Date Coverage Ended (if active list active) (mm/dd/yyyy)

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3. If you or any family member applying for this coverage is currently covered by Blue Cross, Blue Plus, USAble Life, or Delta Dental, do you want that coverage canceled? ☐ Yes ☐ No If **Yes**, provide the individual name, identification number, group number, and cancellation date.

4. COORDINATION OF BENEFITS

Will you or any family member listed under this plan have dual health or medical coverage once this policy is in force? ☐ Yes ☐ No

If the response is Yes, you may be contacted for more information.

5. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and/or 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

DO NOT PROVIDE ANY GENETIC INFORMATION, INCLUDING FAMILY MEDICAL HISTORY INFORMATION.

You do not have to disclose a test to detect the presence of human immune deficiency virus (HIV), or other bloodborne pathogens if such tests were 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; or (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. In the past five (5) years, have you or any family member included on this application been treated for or diagnosed for any of the following conditions? Check each item either "Yes" or "No" and circle conditions:

		Yes	No
A.	Heart, blood, circulatory system disorders including, stroke, high blood pressure, or heart attack	☐	☐
B.	Digestive or intestinal disorders including, ulcers, hernia, hepatitis, gallbladder, or liver disorders	☐	☐
C.	Kidney or urinary tract disorders	☐	☐
D.	Male or female reproductive system disorders including, prostate gland, infertility, or menstrual disorders	☐	☐
E.	Breast disorders including, complications from breast implants	☐	☐
F.	Respiratory system disorders including, emphysema, asthma, allergies, or sleep apnea	☐	☐
G.	Endocrine disorders including, diabetes, thyroid, pancreas, or pituitary gland disorders	☐	☐
H.	Psychological disorders including, attention deficit, behavioral, or eating disorders	☐	☐
I.	Neurological or neuromuscular disorders including, multiple sclerosis, cerebral palsy, or seizure disorders	☐	☐
J.	Muscle, bone, joint or back disorders including, scoliosis, arthritis, or temporomandibular joint disorder (TMJ)	☐	☐
K.	Cancer, tumor, or polyp	☐	☐
L.	Eye, ear, nose, or throat disorders including, cataracts, ear infections, and hearing impairments	☐	☐
M.	Immune system disorder or positive test results including, AIDS, lupus, and scleroderma	☐	☐

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2. Please answer the following questions for you and all family members included on this application: **Yes** **No**

   A. Has any applicant had any surgery or hospitalizations during the past five (5) years? ☐ ☐

   B. Is any applicant currently taking or taken any prescribed medication during the past year? ☐ ☐

   C. During the past 12 months, has anyone experienced back or neck pain, joint or muscle pain, headaches, stomach or abdominal pain, chest pain, shortness of breath or chronic cough, dizziness or fainting episodes, fever, swollen glands or lump, blood in stool or urine, or an injury for which a physician has not been consulted? ☐ ☐

   D. Is any applicant currently pregnant? If **Yes,** list in #5 the due date and describe any complications experienced or if multiple births are expected. ☐ ☐

   E. Has any applicant used tobacco or smokeless tobacco during the past 12 months? If **Yes,** provide details in #5 on the product, duration and frequency of use. ☐ ☐

3. Indicate if you or any family member included on this application in the past five (5) years have: **Yes** **No**

   A. Ever used drugs regularly, other than drugs prescribed by an attending physician, or been treated for the use of drugs or alcohol? ☐ ☐

   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? ☐ ☐

   C. Ever been advised by a health care professional to quit or reduce the use of alcohol or drugs? ☐ ☐

4. Have you or any family member been covered by Minnesota Comprehensive Health Association (MCHA)? **Yes** **No**

   If **Yes,** provide names in #5 of all covered individuals, dates of coverage, and qualifying health risk ☐ ☐

5. Provide full details for all "Yes" answers for questions 1-4. Use extra paper if necessary. Please print all information in black or blue ink.

Question no. & letter	Person Name	Diagnosis or Details about Condition, Treatment, Medication	Date of Onset	Date of Recovery	Days in Hospital	Doctor or Clinic Name

(Continued on page 6)

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 to the best of my knowledge and belief. I understand and agree that Blue Cross, Blue Plus, USAble Life 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 provided to the Blue Cross Underwriting department. 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 from the effective date of coverage. 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.

In order to process your application, we may collect personal information regarding your health history and motor vehicle driving records from persons other than you. You have the right to see your personal records that are maintained by us and to correct personal information we have collected about you. Upon your request, we will furnish a more detailed notice of our information practices. I hereby authorize and request any pharmacy and pharmacy related service organizations or motor vehicle department to furnish Blue Cross full details of pharmaceutical records and driving records about me and to accept as valid a photocopy of this authorization and my signature. We keep this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without authorization. For purposes of obtaining information in connection with this application, this release is valid as long as the applicant is continually insured with the insurer.

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 at least 12 consecutive months, or for late entrants, 18 consecutive months following the enrollment date. Credit will be given for prior continuous qualifying creditable coverage to reduce the preexisting condition limitation period. Please provide details of all other health coverage in Section F. The preexisting condition limitation does not apply to any insured member under age 19.

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. The preexisting condition limitation does not apply to any insured member under age 19. You give up your option for dental benefits if you do not apply for dental coverage when you are first eligible. With respect to life or disability insurance coverage, I understand that I will have to furnish evidence of insurability at my own expense if I apply at a later date.

With respect to life or disability insurance coverage, I understand that no coverage will be effective on me or any eligible dependent if I am not actively at work due to total disability on the proposed effective date of my coverage, or if any eligible dependent is totally disabled on such date.

For the purposes of the application, I understand and agree 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 B of this application. Upon request, I agree to furnish any additional information needed concerning the eligibility of any dependent.

X _____ X _____

Signature Date Employee Signature