BlueCross BlueShield Minnesota

FOR AGENT USE ONLY (Please print legibly)

Agency Code M H I

Agent Number 3 3 4 1

Agent Name Knutson

Individual Special Enrollment Form (Off Exchange)

A Reason for enrolling

☐ I am a new enrollee, not currently a Blue Cross and Blue Shield of Minnesota (Blue Cross) member

☐ I currently have a Blue Cross individual contract and I am: Blue Cross ID # _____

☐ adding a dependent

Enrollment Form instructions

1. Please complete this entire enrollment form including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete enrollment form will be returned to you to be completed. This may affect the date your coverage starts.
2. Sign and date this enrollment form. This enrollment form must be received at the home office of Blue Cross within 15 days of your signature.
3. The enrollment form can be mailed to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164 or fax 651-662-6439 or email Enrollment_forms@bluecrossmn.com.
4. A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by calling one (1) of the phone numbers listed below.

General information

- You must be a resident of Minnesota.
- You must be a citizen of the United States (U.S.) or permanent resident.
- You or any dependent may not be enrolled in Medicare Part A or Part B.
- Enrollees age 20 and under applying as the contract holder can only have single coverage.
- If eligible, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.

After you submit your enrollment form

- You will receive your contract, ID cards, and first bill or automatic withdrawal notification within two (2) weeks.

How to contact us

- Please contact your agent for assistance or call 651-662-5050 or toll-free 1-800-262-0823 and one of our Blue Cross representatives will be happy to assist you.
- This information is also available in other ways to people with disabilities by calling Customer Service at (651) 662-5030 (voice), or 1-800-531-6685 (toll free), for (TDD) call (651) 662-8700, or 1-888-878-0137 (TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TYY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech)
  Hours: 8 a.m.-5 p.m. Central Time, Monday – Thursday; 9 a.m.-5 p.m. Central Time, Friday.
- Attention. If you want free help translating this information, call the above number.
  Atencion. Si desea recibir asistencia gratuita para traduca esta informacion, llame al número que aparece más arriba.
- For Readability and Accessibility call 651-662-5040 or 1-800-711-9875.

B Enrollee information

Enrollee Name _____ Legal Marital Status ☐ Single ☐ Married
FIRST LAST

Enrollee address _____
Street including Apt#

City _____ State _____ Zip _____ County _____

Billing address _____
(if different than above) Street City State Zip County

Preferred telephone number (_____) _____ Alternate telephone number (_____) _____
Telephone type: ☐ home ☐ cell ☐ work Telephone type: ☐ home ☐ cell ☐ work

Preferred Email address _____ Alternate Email address _____

Starting with Enrollee, list each dependent(s) applying for coverage.
If you or any dependent enrolling for coverage is not a U.S. citizen, but are a permanent resident of the U.S., you must provide documents confirming immigration status:

	Name First	Name Last	Social Security Number	Relationship to Enrollee	Birth Date mm/dd/yyyy	Sex M/F
1.				Enrollee		
	☐ Yes ☐ No I am a Minnesota resident,		☐ Yes ☐ No I am a citizen of the U.S., if No;			
	☐ Yes ☐ No I am a permanent resident of the U.S., if Yes; country of citizenship _____					
2.						
	☐ Yes ☐ No Citizen of the U.S., if No; ☐ Yes ☐ No Permanent resident of the U.S., if Yes; country of citizenship _____					
3.						
	☐ Yes ☐ No Citizen of the U.S., if No; ☐ Yes ☐ No Permanent resident of the U.S., if Yes; country of citizenship _____					
4.						
	☐ Yes ☐ No Citizen of the U.S., if No; ☐ Yes ☐ No Permanent resident of the U.S., if Yes; country of citizenship _____					
5.						
	☐ Yes ☐ No Citizen of the U.S., if No; ☐ Yes ☐ No Permanent resident of the U.S., if Yes; country of citizenship _____					
6.						
	☐ Yes ☐ No Citizen of the U.S., if No; ☐ Yes ☐ No Permanent resident of the U.S., if Yes; country of citizenship _____					

☐ Additional dependent(s) on attached page

C Payment selection

Choose your preferred payment option, applies to both medical and dental, the two (2) options will be:
☐ Monthly automatic withdrawal; **or** ☐ Bill me monthly

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D Other Coverage

1. Does any dependent(s) applying for coverage currently have Blue Cross Blue Shield of Minnesota coverage? Yes ☐ No ☐

If Yes:

Dependent Name	Identification Number

2. Will you or any dependent(s) 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.

3. Will you or any dependent(s) named on this Enrollment Form be enrolled in either Medicare Part A or Medicare Part B or both? Yes ☐ No ☐

E Plan selection

Before enrolling in one of the plans, you must validate that the plan you are selecting has doctors in the service area that you want to use.

BlueBasic	BluePrint	BlueConnect	BlueAccess
Single/family coverage	Single/family coverage	Single/family coverage	Single/family coverage
Consumer Value Network	Allina Health Network	Sanford Health Network	Aware Network
50% Plan ☐ $3,300 (AAE7) 80% Plan ☐ $2,200 (AAE9) 100% Plan ☐ $4,350 (AAEA) ☐ $5,650 (AAE8)	80% Plans ☐ $1,500 (AADR) ☐ $1,900 (AADP) 100% Plan ☐ $1,000 (AADT)	80% Plans ☐ $1,500 (AADJ) ☐ $1,900 (AADG) 100% Plan ☐ $1,000 (AADL)	80% Plan ☐ $0 (AAE3) 90% Plan ☐ $0 (AAE4) 100% Plan ☐ HSA $1,800/single - $3,600/family (AAE1) ☐ HSA $3,150/single - $6,300/family (AADX) ☐ HSA $5,200/single - $10,400/family (AAE5)
BlueSave	**BlueValue**		
Single/family coverage	Single/family coverage		
Consumer Value Network	Blue Performance Regional Network		
100% Plan ☐ $5,650 (AADW)	80% Plan ☐ $2,400 (AADV)		

The deductible, copay and out-of-pocket maximum amounts are subject to annual adjustments. These adjustments are based on the percentage by which the average U.S. per capita premium for health insurance coverage for the preceding year exceeds the average U.S. per capita premium for health insurance in 2013. These annual adjustments are effective on the annual renewal date.

Pediatric dental coverage is an essential health benefit required in all health plans. Rates are applied to enrollee and dependent(s) through age 18 via a separate contract with Delta Dental*. Enrollees, on behalf of all their dependents, may opt out of pediatric dental coverage with proof of exchange - certified pediatric dental coverage.

Do you currently have a plan with a pediatric dental coverage with proof of exchange - certified pediatric dental coverage? (Call your dental plan to verify). Pediatric dental coverage will be included if the name of Dental Insurance Company or Policy Number is missing.

☐ Yes Name of Dental Insurance Company _____ Policy Number_____

☐ No The health plan you select will include pediatric dental coverage, via separate contract with Delta Dental, and rates apply to enrollee, spouse, and dependent(s) through age 18.

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F Special Enrollment

Below is a list of common special enrollment triggering events. Check the event below, and/or add additional information regarding the reason for enrolling outside of open enrollment. _____

Triggering Event	Required Documentation(s)	Notice Period	Coverage Effective Date
Acquiring a new dependent			
☐ Newborn	Child's full name, date of birth, and county	60 days from the date of the triggering event	Date of the birth, adoption, placement for adoption, or court ordered
☐ Newborn grandchild	Child's full name, date of birth, and county and/or dependent grandchild form (X197247)		
☐ Adoption/Placement of adoption	Court / Placement document(s)		
☐ Court ordered	Court document(s)		Marriage. First day of the month following receipt date
☐ Marriage	Date of Marriage and county		
Loss of Minimum Essential Coverage/Misc.			
☐ Loss of eligibility for employee coverage	Cobra notice	60 days from triggering event to select plan.	First day of the month following receipt date
☐ Term employment or reduction in hours	Cobra notice		
☐ Plan no longer offers benefits	Letter from employer		
☐ Employer bankruptcy	Letter from employer		
☐ Legal separation/divorce	Court document(s)		
☐ Loss of dependent child status	Letter from previous carrier and/ or court document(s)		
☐ Death of employee	Date of death and county		
☐ Moving outside HMO service area	Proof of address change		
☐ Termination of employer contributions	Letter from previous employer		
☐ COBRA exhaustion	Letter from previous carrier		
☐ Employee becomes entitled to Medicare (only if loss of coverage)	Medicare enrollment documentation		
Misc.			
☐ Enrollment is unintentional, Inadvertent or erroneous due to Exchange error	Documents from the Exchange	60 days from triggering event to select plan.	Receipt date between 1st and 15th = First day following month. Receipt date between 16th and the last day = First day of the second following month
☐ QHP substantially violates material provision of contract	Documents from the Exchange		
☐ Gain access to new Qualified Health Plan (QHP) due to a permanent move	Proof of address change		
☐ Eligibility for Advance Premium Tax Credit (APTC) changes (either way) or employer-sponsored coverage will not be affordable or provide minimum value	Notice from MNsure		
Non-Calendar Year Plan			
☐ Individual enrolled in non-calendar year plan	Letter from previous carrier	30 days prior to date policy ends in 2014 only	Receipt date between 1st and 15th = First day following month. Receipt date between 16th and the last day = First day of the second following month

Please complete if event reason is: Newborn, Newborn grandchild, Marriage or Death of employee:

_____ _____ _____ _____

Full name | Date of Birth (if applicable) | Date of event | County of event

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G Authorization and representation

I understand and agree that coverage, if approved, will begin as specified in section F on page 4. I authorize Blue Cross and Delta Dental of Minnesota either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross and Delta Dental of Minnesota uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross and Delta Dental of Minnesota receives my check and I will not receive my check back from my financial institution.

I understand that coverage will be provided under an individual contract. I understand that Blue Cross and Delta Dental of Minnesota do not issue individual coverage through any arrangement with an employer. Blue Cross and Delta Dental of Minnesota are not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

I agree if I am enrolling in a product that features certain designated providers, Blue Cross may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this enrollment form in the decision whether to accept the enrollee and/or dependent(s) listed on this enrollment form for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the enrollment form, even if the enrollee, and/or dependent(s) listed on this enrollment form, currently have coverage or had prior coverage with Blue Cross.

I understand and agree that payment of a claim does not preclude the right of Blue Cross and Delta Dental of Minnesota to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I agree to notify Blue Cross and Delta Dental of Minnesota immediately of any change in my (or my dependent(s)) enrollment information between the date of this enrollment form and the effective date of coverage. Failure to notify Blue Cross and Delta Dental of Minnesota of any change in the information contained on this enrollment form may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependent(s) enrolling for coverage.

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Cross and Delta Dental of Minnesota will act in reliance upon the information I have provided on this enrollment form which materially affect enrollment eligibility may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

If this enrollment form is completed as an electronic or online enrollment form, both parties agree to conduct this transaction electronically.

X _____ X _____

Date — Enrollee, Parent, Legal Guardian or Guarantor Signature (if contract holder is a minor)

* Delta Dental is an independent company providing dental benefit coverage.

H Agent

IF ENROLLMENT FORM COMPLETED BY AGENT, COMPLETE AND SIGN BELOW

If enrollment form was completed by agent, agent certifies that he/she personally completed this enrollment form, that each question was asked separately, that the answers recorded on this enrollment form are complete and accurate as provided by the enrollee.

X _____ ( ) _____ _____

Agent Signature — Agent Telephone Number — Date