



BluePride Employee Enrollment Form

FOR INTERNAL USE
Group Number
Group Department

- New Group
New Hire
Change

Please print and complete all sections of this enrollment form with black ballpoint pen. Be sure to complete all questions in full. Incomplete enrollment forms cause unnecessary delays. If you need more space for any answers, you can use a separate piece of paper. Please include your name and social security number. Complete Section B, if applicable.

Section A. APPLICANT INFORMATION

Form fields for Section A: Social Security Number, Name (Last, First, M.I., Title), Gender, Date of Birth, Height, Weight, Home Phone Number, Work Phone Number, Cell Phone Number, Marital Status, Address, Group Name, 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, your spouse or your dependent(s) terminating other Blue Cross and Blue Shield coverage? Yes No If Yes, please give reason and date (mmddyyyy):

Section B. DECLINATION OF COVERAGE. Complete only if you elect not to participate in the group insurance offered.

The group health/dental program has been offered to me and after seriously considering its benefits, I have decided:

- not to enroll myself in the health/dental plan.
not to enroll myself and my dependents in the health/dental plan.
not to enroll my dependents in the health/dental plan.

Coverage in the health/dental 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)

Signature of Applicant: Date:

Section C. HEALTH AND DENTAL ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES.

I HEREBY APPLY FOR:

Form for Section C: HEALTH, DENTAL, and MEDICARE SUPPLEMENTAL options with checkboxes and input fields for deductibles and account types.

Section D. PERSONAL DATA

List below spouse and other dependent(s) to be covered including unmarried dependent children under age 19 and any full time student dependents. List in order of age - oldest first.

Table with 9 columns: Full Name (Last, First, M.I.), Social Security Number, Date of Birth (mmddyyyy), Height, Weight, Sex, Relation to Employee, Name of School (If Dependent is Age 19 or over), Credit Hours per Semester.

**Section E. COVERAGE CHANGE ELECTION(S) FOR CURRENT MEMBERS**

**I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE:**     **Health Only**     **Dental Only**     **Both**

Change to One Person Coverage     Change to Employee and Child(ren) Coverage     Change to Family Coverage     Change to Employee and Spouse Coverage

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 F. HEALTH HISTORY**

ANSWER EACH QUESTION YES or NO. For conditions answered "YES," give details below.

**This information is necessary for rating and reinsurance review purposes for health insurance and for underwriting of life coverage, if applicable. Your application for health coverage will not be declined based on answers to these questions, or any health status-related factors. If you are a new hire or are changing your coverage, you are not required to complete this section. To request a copy of our Privacy Policy, contact us: in Omaha 390-1820, toll free 800-642-8980**

The following questions pertain to YOU AND ANY ELIGIBLE DEPENDENTS APPLYING FOR COVERAGE.

1. Are you or any of your dependents currently pregnant? Due Date \_\_\_\_\_  YES     NO
2. Are you or any of your dependents currently ill or taking any medications?  YES     NO
3. Within the past twelve months, have you or any dependents used tobacco products?  YES     NO
4. Within the last 5 years, have you or any of your dependents:
  - a. Consulted or been examined, advised or treated by any doctor, chiropractor, counselor, therapist or any other medical practitioner?  YES     NO
  - b. Been hospitalized or undergone any medical testing or treatment?  YES     NO
  - c. Been advised of the need for any future treatment or surgery?  YES     NO
  - d. Been diagnosed or received treatment for cancer; heart, liver, kidney, or lung disease; alcohol or drug abuse; diabetes; back, spine, or joint problems; nervous or mental problems; seizures; stroke; stomach, intestinal, or esophagus problems?  YES     NO
  - e. Been convicted of a DWI offense or had a drug or alcohol evaluation?  YES     NO

If yes to question 4e, please give details, including dates \_\_\_\_\_

Was there a finding of alcohol or drug dependency?     Yes     No

If yes, give date of last use of alcohol (or drugs, if applicable).    Month/Year: \_\_\_\_\_

**For any "YES" answers identified above, please provide complete details below. Attach a separate piece of paper if necessary.**

Medical Questionnaires may be requested when more information is necessary on certain conditions:

Question	Name of Person	Name of Condition (Diagnosis)	Dates Seen (From - To)	Describe Treatment Details, Surgery, etc.	Estimated # of Health Care Visits Over the Past 2 Years	Degree of Recovery

**List the names of any medications taken in the past 24 months and the reason for taking them.**

Name of Person	Name of Medication	Reason	Date First Prescribed	Date of Last Use

**Section G.**

**If any of these conditions are present, please answer the applicable question(s):**

- 1) **Seizures or Epilepsy:** Give date of last seizure. Identify type of seizures: Name \_\_\_\_\_ Date \_\_\_\_\_  
 Petit Mal  Grand Mal  Other \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_
- 2) **High Cholesterol:** Give the most recent cholesterol level and date taken. Name \_\_\_\_\_ Level \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Level \_\_\_\_\_ Date \_\_\_\_\_
- 3) **Diabetes:** Give the most recent hemoglobin A1C level or fasting blood sugar and date taken. Name \_\_\_\_\_ Level \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Level \_\_\_\_\_ Date \_\_\_\_\_

**Section H.**

I represent that my answers and statements in this application are true and complete to the best of my knowledge and belief. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for this review. I authorize my employer to deduct from my earnings any required premiums. I understand that coverage is not in force unless or until my employer enters into a contract with Blue Cross and Blue Shield of Nebraska.

**WAITING PERIOD FOR PRE-EXISTING CONDITIONS NOTICE**

This Plan imposes a waiting period for pre-existing conditions. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in an eligibility waiting period for coverage, the six-month waiting period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the waiting period for pre-existing conditions and creditable coverage should be directed to our Member Services Department at (402) 390-1820 or toll-free 1-800-642-8980.

**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 30 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 30 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.

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**Description and Purpose of Authorization** – I authorize any health care provider, pharmacy and pharmacy related service organizations, to release my protected health information (PHI) to Blue Cross and Blue Shield of Nebraska (BCBSNE) for the purpose of determining premium rates and medical rating of the group.

I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcriber hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. I understand that my PHI may include information relating to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug abuse).

**Terms and Conditions of Authorization** – I understand I may revoke this authorization in writing at any time. Revocation of this authorization will not affect any action taken by BCBSNE in reliance on this authorization. Unless revoked earlier, this authorization will expire upon an offer of coverage from BCBSNE.

I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be protected by federal regulations governing the privacy of health information.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**If you have a certificate of creditable coverage, please attach it to this enrollment form. If you do not, please send a copy to the following address as soon as you've received it: Blue Cross Blue Shield of Nebraska, P.O. Box 3248, Omaha, NE 68180-0001. Failure to provide this documentation may affect your waiting periods and/or claim payments.**