



BlueFreedom Health 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.

A. APPLICANT INFORMATION

Form fields for Applicant Information: Social Security Number, Name (Last, First, M.I., Title), 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 (mmddy):

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 another insurance company
Other reason(s)

Signature of Applicant: Date:

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

I HEREBY APPLY FOR:

Form for Health and Dental Election: HEALTH, Dual Option Group, High Deductible Health Plan, DENTAL, MEDICARE SUPPLEMENTAL.

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 (mmddy), Height, Weight, Sex, Relation to Employee, Name of School (If Dependent is Age 19 or over), Credit Hours per Semester.

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; Reason: () Divorce () Spouse Deceased
 () Other Change Date _____

Change to Family Coverage Change to Employee and Spouse Coverage: Date of Marriage _____

Add New Dependent(s): Date Dependent(s) joined your household _____ (Complete Section D.)

Other Health Changes: _____

F. HEALTH HISTORY - Please answer each question Yes or No and explain any Yes answers below. This information is necessary for rating purposes. Your enrollment for health coverage will not be declined based on your 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.

1. In the past 5 years, have you or any of your dependents been tested, diagnosed or treated (including prescription medication usage) or been advised to seek treatment for:
 1. Alcohol or drug abuse Yes No
 2. Arthritis, Bone, Joint, Spine, Muscle or Connective Tissue Disorder Yes No
 3. Autoimmune disease, including Crohn's disease, Lupus or Multiple Sclerosis Yes No
 4. Cancer, tumors or polyps Yes No
 5. Circulatory, blood or heart disorders including high blood pressure Yes No
 6. Cirrhosis, hepatitis or any other disease of the liver Yes No
 7. Cystic Fibrosis or Rheumatic Fever Yes No
 8. Digestive disorders including any conditions of the colon, esophagus, gallbladder, intestines, pancreas or stomach Yes No
 9. Diabetes, hyperthyroidism, hypothyroidism or any endocrine disorder or disease Yes No
 10. Genetic or developmental disorders including use of growth hormones Yes No
 11. HIV / AIDS or any other immune system disorder Yes No
 12. Infertility or any other reproduction system disorder Yes No
 13. Lung disease or disorder Yes No
 14. Neurological disorders including Alzheimer's, Cerebral Palsy, Epilepsy, migraines, Parkinson's or seizures Yes No
 15. Organ transplant Yes No
 16. Paralysis including paraplegia and quadriplegia Yes No
 17. Vascular disorders including stroke, CVA or TIA Yes No

2. In the past 5 years, have you or any of your dependents been hospitalized, had surgery or plan to have surgery for any illness, injury or condition or is anyone currently pregnant? Yes No

3. In the past year, have you or any of your dependents incurred medical or pharmacy expenses in excess of \$5,000? Yes No

Question Number	Person	Condition	Treatment Performed or Recommended	Degree of Recovery

Applicant's Name (Last)	(First)	(M.I.)	(Title)	Social Security Number
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G. I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. The Preadmission Certification Program has been explained to me. I understand that all hospitalizations must be precertified by Blue Cross and Blue Shield of Nebraska, or benefits will be reduced. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

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 Customer Service Center 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.

To request special enrollment or obtain more information contact our Customer Service Center 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 enrollment, eligibility for benefits, underwriting and any other activities related to the creation, renewal or replacement of a contract for health insurance or health benefits.

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 that signing this authorization is a condition of my enrollment in BCBSNE's health plan and for my eligibility for benefits. If I decide not to sign this authorization, BCBSNE may decline to enroll me in the health plan or to provide the benefits, or BCBSNE may disenroll me from the health plan.

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. If I revoke this authorization before BCBSNE has received and used the PHI described above, BCBSNE may decline to enroll me in the health plan. 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.