BlueCross BlueShield of Nebraska

P.O. Box 3248 • Omaha, Nebraska 68180-0001
An Independent Licensee of the Blue Cross and Blue Shield Association.

Group Health Enrollment Form with High Deductible Health Plan (HDHP) Option

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 (press firmly). 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.** Distribution: White (original) - BlueCross BlueShield of NE; Green Copy - Employer

A. APPLICANT INFORMATION

Social Security Number | Name (Last) (First) (M.I.) (Title) | ☐ Male ☐ Female

Date of Birth (mmddyy) | Home Phone Number ( ) | Work Phone Number ( ) | Cell Phone Number | Marital Status: ☐ Single ☐ Married ☐ Divorced

Address (Street, P.O. Box, Apt. #) (City) (State) (Zip+4 Code) (County)

Group Name (Employer or Organization) | Date employed with Group (mmddyy) | 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 (mmddyy):

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

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

☐ not to enroll myself in the health plan.
☐ not to enroll myself and my dependents in the health plan.
☐ not to enroll my dependents in the health plan.

Coverage in the health 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)________________________________

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.

Signature of Applicant:________________________________ Date: ________________

C. HEALTH ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES

I HEREBY SELECT: ☐ **BASE PLAN** or ☐ **HSA - eligible High Deductible Health Plan**
☐ One Person ☐ Family ☐ Employee and Spouse ☐ Employee and Child(ren)

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.

Full Name (Last, First, M.I.)	Social Security Number	Date of Birth (Mo., Day, Year)	(X) Sex M	F	Relation to Employee	Name of School (If Dependent is Age 19 or over)	Credit Hours per Semester

Name (Last)	(First)	(M.I.)	(Title)	Social Security Number

E. HEALTH CHANGE ELECTION(S) FOR CURRENT MEMBERS

I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE:

☐ Change to One Person Health ☐ Change to Employee and Child(ren) Health; Reason: ( ) Divorce ( ) Spouse Deceased
( ) Other Change Date ________________________________

☐ Change to Family Health ☐ Change to Employee and Spouse Health: Date of Marriage ______________________________

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

☐ Other Health Changes:____

F. 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.

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.