Application and Waiver Form for Group Coverage

Complete this application in its entirety in blue or black ink.
Do not use a pencil or a highlighter.

Eff. 11/1/2020
Filed 3/14/2018
29378830A GRP FI
POD 8-20

☐ **Enrolling** (Complete sections I, II, III and IV) ☐ **Waiving** (Complete sections I and V) ☐ **Changes to Existing Coverage** (Complete sections I, II, III and IV)

I EMPLOYEE/CONTRACT HOLDER INFORMATION *(Must be completed for both enrollees and waivers)*

Employer/Group Name

Medical Group Number if applicable	Dental Group Number if applicable	Vision Group Number if applicable
Effective Date	Payroll Location	

First Name	MI	Last Name	Social Security Number

Address

City	State	Zip	County

Home Phone	Work Phone	Mobile Phone

Marital Status *(Please check one)*: ☐ Single/Widowed ☐ Divorced ☐ Married Give Date if Changing Status (Month/Day/Year) _____ /____ /_____

Full-Time Hire (or Rehire) Date (Month/Day/Year) _____ /____ /_____	Hours Worked Per Week	Job Title

Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) _____ /____ /_____	Age

Product Selection(s) ☐ Medical Product Name: _____ ☐ Dental ☐ Vision

Provider Network Name, if applicable

☐ Yes ☐ No Will any portion of the premium be paid by your employer or your spouse's employer, either directly or through wage adjustments or other means of reimbursement?

☐ Yes ☐ No Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code? (See back page "Coverage Information" for additional explanation.)

II DEPENDENT INFORMATION *(If enrolling more than four dependents, please attach a separate sheet)*

SPOUSE

First Name	MI	Last Name	Relationship to You? ☐ Spouse ☐ Domestic Partner

Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) _____ /____ /_____	Social Security Number

Age	Product Selection(s) ☐ Medical ☐ Dental ☐ Vision

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted* ☐ Legal Guardian*

Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) _____ /____ /_____	Age

Social Security Number (If no SSN, write N/A)	Product Selection(s): ☐ Medical ☐ Dental ☐ Vision

*If newly enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted* ☐ Legal Guardian*

Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) _____ /____ /_____	Age

Social Security Number (If no SSN, write N/A)	Product Selection(s): ☐ Medical ☐ Dental ☐ Vision

*If newly enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

Producer Number	**Producer Name**
54	Ryan Hartje

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted* ☐ Legal Guardian*
Gender ☐ Male ☐ Female		Date of Birth (Month/Day/Year) _____ /____ /_____	Age
Social Security Number (If no SSN, write N/A)		Product Selection(s): ☐ Medical ☐ Dental ☐ Vision	

*If newly enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III OTHER HEALTH INSURANCE COVERAGE

MEDICARE COVERAGE *(Please list any family member that is eligible for Medicare Benefits)*

Name of Subscriber or Dependent	Medicare Beneficiary Number	Effective Dates			Check (√) Reason for Medicare Coverage			Medicare Supplement or Complement
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								☐ Yes ☐ No
								☐ Yes ☐ No

IV APPLICANT SIGNATURE *(Required for enrollment and changes)*

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively canceling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X	
Applicant's Signature	Date Signed

V WAIVER OF COVERAGE FORM *(Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members)*

I HEREBY DECLINE: ☐ Medical ☐ Dental ☐ Vision For myself

I HEREBY DECLINE: ☐ Medical ☐ Dental ☐ Vision For family members **ONLY**

I HEREBY DECLINE: ☐ Medical ☐ Dental ☐ Vision For myself and **ALL** family members

I HEREBY DECLINE: ☐ Medical ☐ Dental ☐ Vision For the following family members: _____

REASON FOR DECLINING MEDICAL COVERAGE:

☐ I have coverage through my spouse's employer or another group health plan

☐ I have individual coverage

☐ I have Medicare Parts A and B

☐ I have coverage under CHAND

☐ I have coverage under medical assistance or general assistance medical care

☐ Other _____

REFUSAL OF COVERAGE

The group Benefit Plan provided by my employer has been explained to me thoroughly, and I understand it fully. I elect not to participate and understand that I will not be entitled to any benefits provided by the group Benefit Plan. I make this election voluntarily and under no compulsion or duress.

ONLY SIGN BELOW IF YOU ARE WAIVING COVERAGE

Employee/Contract Holder Signature	Date

Special Enrollment Rights:

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 in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free BCBSND Member Services number: 844-363-8457 (TTY/TDD: Dial 711).

Coverage Information

I understand if I pay any portion of my health insurance premiums using pretax dollars (Section 125) or my employer pays any portion of my health insurance premiums (Section 106) or provides reimbursement for uninsured medical expenses for me and my dependents (Section 162), I should answer "yes" to the question, "Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code?" (located in Section 1, Employee/Contract Information).

BlueSaver Benefit Plan

I understand the BlueSaver Benefit Plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account. I also understand BCBSND does not provide tax, investment or legal advice. If I have questions about a Health Savings Account or the tax implications of the BlueSaver Benefit Plan, I should contact a qualified tax, investment or legal professional.

Limitations and Exclusions

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

Conversion Rights for Health Coverage

In the event the group through which I am enrolled elects to terminate, BCBSND has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.

Conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with BCBSND and has enrolled as a group with another insurance carrier.

Method of Payment

In the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing.

Contact Us

Visit us on the web: www.BCBSND.com | **Member Services toll-free:** 844-363-8457

Visit one of our offices:

Home Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (844) 363-8457

Fargo District Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2232

Grand Forks District Office
3570 S. 42nd St., Suite B
Grand Forks, ND 58201
Phone: (701) 795-5340

Dickinson Office
1674 15th St. W., Suite D
Dickinson, ND 58601
Phone: (701) 225-8092

Bismarck District Office
1415 Mapleton Ave.
Bismarck, ND 58503
Phone: (701) 223-6348

Minot District Office
1308 20th Ave. SW
Minot, ND 58701
Phone: (701) 858-5000

Devils Lake Office
425 College Dr. S., Suite 13
Devils Lake, ND 58301-3537
Phone: (701) 662-8613

Jamestown Office
300 2nd Ave. NE, Suite 132
Jamestown, ND 58401
Phone: (701) 251-3180

Williston Office
1137 2nd Ave. W., Suite 105
Williston, ND 58801
Phone: (701) 572-4535