



Complete Highlighted Fields

Enrollment/Waiver Form
 Complete this Application in its entirety
 in blue or black ink.
 Do not use pencil or highlighter.
 For cancellations use form F8708

- Enrolling**
(Complete sections I, II, IV, and V)
- Waiving**
(Complete sections I and III)
- Information Changes**
(Complete sections I and II)

I Employee/Contractholder Information (Must be completed for both enrollees and waivers)

Effective Date 01/01/2018	Employer/Group Name City of Windom	Group Number 10203059	Payroll location/Dept. #
First Name	MI	Last Name	*Social Security Number (if no SS#, write N/A)
Address			
City	State	Zip	County
Home/Cell Telephone			
E-mail address			

Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married	Enrollment Status <input checked="" type="checkbox"/> Active Employee <input type="checkbox"/> Rehired Employee	<input type="checkbox"/> Employment Change From Part-Time to Full-Time <input type="checkbox"/> COBRA Continuant Start Date ____/____/____ <input type="checkbox"/> Special Enrollment Event _____ Date ____/____/____	
Full-Time Hire (or Rehire) Date (mm/dd/yyyy) / /	Hours Worked Per Week	Primary Care Clinic # (if applicable)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy) / /	Age	Product Selection(s) (if your employer offers these coverage options): <input type="checkbox"/> Medical Product Name: <small>See separate form</small> <input type="checkbox"/> Dental Product Name: _____ <input type="checkbox"/> Vision Product Name: _____

***Social Security Numbers (SSN) for you and your dependents are requested but not required.**

II Dependent Information (If enrolling more than four dependents, please attach a separate sheet)

Spouse / Domestic Partner

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
*Social Security Number (if no SS#, write N/A)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy) / /	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			Primary Care Clinic # (if applicable)	

Dependent #1

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted^ <input type="checkbox"/> Other^	
*Social Security Number (if no SS, write N/A)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy) / /	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			Dependent Status if Age 26 or Older: <input type="checkbox"/> Disabled	
Primary Care Clinic # (if applicable)				

Dependent #2

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted^ <input type="checkbox"/> Other^	
*Social Security Number (if no SS, write N/A)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (mm/dd/yyyy) / /	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			Dependent Status if Age 26 or Older: <input type="checkbox"/> Disabled	
Primary Care Clinic # (if applicable)				

^ If 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.

V Important: Authorized Signature Required - Continued

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

I understand that neither the medical plan nor the dental plan includes coverage for the pediatric dental essential health benefit and that The Company has made me aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit www.mnsure.org.

I agree to notify The Company immediately of any change in my or my family member's enrollment information between the date of this Application and the effective date of coverage. Failure to notify The Company of any change in the information contained on this Application may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

Upon request, I agree to furnish any additional information needed concerning the eligibility of any family member applying for coverage.

The Company may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include any person or entity from which The Company is not required by law to accept such third-party payments. This may include, for example, commercial entities, healthcare providers and suppliers, and other persons or entities with direct or indirect pecuniary interests. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic fund transfer, etc. If you have questions about this third party payment policy or whether The Company will accept premium and/or cost-sharing payments made by a specific person or entity, please contact your employer.

I acknowledge that I am not applying for this coverage in connection with any offer from any ineligible third-party to pay any premium or cost-sharing related to this plan.

I understand that the health plan I have selected may contain a limited number of providers in the network listed on my application, the providers in the network may change from time to time, and not every provider is in-network for my plan. I also understand and acknowledge that with limited exceptions if I visit a provider or a location that is not in-network, I will pay more for my care, and these costs will count towards any applicable Out-of-Network cost sharing (e.g., the Out-of-Network deductible and Out-of-Pocket [Limitation / Maximum]).

By providing your email address, you agree to receive communications and/or marketing materials related to the Plan you selected and products offered by or made available from The Company and its affiliates. You may unsubscribe or change your email address at any time by following the instructions included in each email communication.

By providing your phone number, you expressly consent to accept and receive communications and /or marketing materials related to the Plan you selected and products offered by or made available from The Company and its affiliates, via text message or voice call to your mobile device and to the cellular/mobile telephone number(s) that you provided to us.

WARNING: E-mail and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an email or text message from an unsecured email or device, The Company, does not accept liability for any errors or omissions in the contents of this message, which arise as a result of e-mail or text message transmission.

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 The Company will act in reliance upon the information I have provided on this Application and that any false information, omissions or misstatements on this Application which materially affect enrollment eligibility may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

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

City of Windom

Print Employee/Contractholder Name

Print Employer/Group Name

Employee/Contractholder Signature

Date

- Please contact your employer or your employer's Agent or Broker for assistance.
- This information is available in other ways for people with disabilities who need it translated into another language by calling 1-800-382-2000 (toll free). For TTY, call 711. Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

Submission Instructions - Employees: Please return your completed form to your employer.

Employers: Completed employee forms should be returned to Blue Cross via the following -

- **New Group Business:** Please refer to your agent or benefits administrator.
- **Open Enrollment:** Employees and dependents who want the effective date of their coverage to be on the annual renewal date of the employer's plan (during the 30 day period before the annual renewal date) and
- **Ongoing Enrollment:** Adding new employees/contractholders/or dependents to an existing group.

Please submit on the employer portal; or fax, email or mail to Blue Cross:

Fax (651) 662-7258 / Enrollment.Forms@bluecrossmn.com

Blue Cross and Blue Shield of Minnesota

P.O. Box 64024

St. Paul, MN 55164-0024

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
M495
PO Box 64560
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by phone at:
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

image_0006_NDL_Portrait (09/16)

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.