

	NI AND CHANGE I ON	11101	RUCTIO	NS FOR CHA	ANGES ON F	PAGE 2			
Employee's Last name	First name	M.I.		Date of Birth Social S		curity Number	Home pho	Home phone	
Employee's Home address Street		City			State	Zip Code	Work phor	ne	
imployee's Email address									
B. LIST ALL INDIVIDUALS TO BE AD	DDED OR CANCELLED	COMP	Ι ΕΤΕ ΔΙ	Ι ΤΗΔΤ ΔΡΡ	I V (use extr	a naner if ne	ressary)		
Relation			Cancel	Add/	Sex Mar	tal Social	Security #	Birth Date	
(check) Last name	First name	M.I.	Eff. Date	Add	Stat		· ·	(Mo. Day Yr.)	
				Cancel Add	F Sin M Ma				
Spouse				Cancel	F Sin	gle			
Child Stepchild				Add Cancel	M Mai F Sin				
Child Stepchild				Add Cancel	M Mai				
Child	,			Add	M Ma	ried			
□ Stepchild C. BENEFIT SELECTION CHECK AF	DDRODRIATE ROYES TO	FI FCT C	R \/\Δ \/I	<u> </u>	F Sin	gie			
Elect or Waive Vision (dependents) UNDERSTAND THAT PROVIDING FALSE IN	IEODMATION IN THIS ADDI I								
, ,	OR CANCELLATION OF COV		X Signatur	e of employee				Date signed	
MAY RESULT IN THE DENIAL OF CLAIM(S) C D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY)	OR CANCELLATION OF COV			e of employee		Hours work	ked per week	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY)	BY EMPLOYER : Employee's occupation:			e of employee		Hours work	ked per week	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying	BY EMPLOYER : Employee's occupation: for salary-based benefits):			e of employee		Hours work	ked per week	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying	BY EMPLOYER : Employee's occupation: for salary-based benefits):	ÆRAGE.	Signatur	e of employee		Hours work	· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro	BY EMPLOYER : Employee's occupation: for salary-based benefits): colling for coverage: Rehire (ÆRAGE.	Signatur				· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee	BY EMPLOYER : Employee's occupation: for salary-based benefits): Dilling for coverage: Rehire (PERAGE.	Signatur				· 	,	
D. THIS PART TO BE COMPLETED BE Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee Return from leave of absence (length	BY EMPLOYER : Employee's occupation: for salary-based benefits): plling for coverage: Rehire (n of absence): Change	length of	Signatur				· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee Return from leave of absence (length Previously waived coverage Certificate of coverage termination	BY EMPLOYER : Employee's occupation: for salary-based benefits): plling for coverage: Rehire (n of absence): Change	length of	Signatur	full-time			· 	,	
D. THIS PART TO BE COMPLETED BE Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enrown New employee Return from leave of absence (length Previously waived coverage Certificate of coverage termination Date of event:	BY EMPLOYER : Employee's occupation: for salary-based benefits): plling for coverage: Rehire (n of absence): Change	length of	Signatur	full-time			· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee Return from leave of absence (length Previously waived coverage Certificate of coverage termination Date of event: Group numbers:	BY EMPLOYER : Employee's occupation: for salary-based benefits): plling for coverage: Rehire (n of absence): Change	length of	layoff): _	full-time		☐ New g	· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee Return from leave of absence (length Previously waived coverage Certificate of coverage termination Date of event: Group numbers:	BY EMPLOYER : Employee's occupation: for salary-based benefits): Dilling for coverage: Rehire (of absence): Change Other: Health subgroup #:	length of	layoff): _	full-time		☐ New g	· 	,	
D. THIS PART TO BE COMPLETED B Employee's date of employment (MM/DD/YY) Monthly salary (complete only if applying Indicate the reason employee is enro New employee Return from leave of absence (length Previously waived coverage Certificate of coverage termination Date of event: Group numbers: Health group #:	BY EMPLOYER : Employee's occupation: for salary-based benefits): Dilling for coverage: Rehire (of absence): Change Other: Health subgroup #:	length of	layoff): _	full-time		☐ New g	· 	,	

Will you, or any person listed abo	ve be covered by other	health insurance or Me	dicare while enro	olled under this coverage	? Yes No	
If yes, you must complete the fe	ollowing (for Medicare,	list both Part A and B e	fective dates):			
Name of policy holder		Insurance company			Type of coverage	Effective
		and address			(single or family)	date
If Medicare; check reason for e	ntitlement Age	Disability End-st	age Renal Diseas	e		
	Disability	End-stage Renal Diseas	se			
F. COVERAGE CHANGE INFO	DRMATION CHECK	APPROPRIATE BOX(ES	S) AND COMPLE	TE SECTIONS A, B AND) C	
Adding dependents:	Date of event		Can	celling dependents:	Date of ev	/ent
Birth/adoption						
		_		Divorce		
Court order		_		Divorce Other (explain in details)):	
		County:):	
Court order		County: Details:):	
Court order Marriage Other Loss of prior health and/or dent	al coverage:	_):	
Court order Marriage Other	al coverage:	Details:		Other (explain in details):	
Court order Marriage Other Loss of prior health and/or dent	Yes No	_		Other (explain in details) Address change):	
Court order Marriage Other Loss of prior health and/or dent. Did you lose health coverage?:	Yes No	Details:		Other (explain in details Address change Phone number change):	
Court order Marriage Other Loss of prior health and/or dent Did you lose health coverage?: Other coverage voluntarily	Yes No terminated A) period exhausted	Details:		Other (explain in details Address change Phone number change):	

Blue Cross and Blue Shield of Minnesota and Blue Plus P.O. Box 64024 St. Paul, Minnesota 55164-0024

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