



A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM -- INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone
Employee's Home address	Street	City	State	Zip Code	Work phone
Employee's Email address					

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED -- COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (check)	Last name	First name	M.I.	Cancel Eff. Date	Add/Cancel	Sex	Marital Status	Social Security #	Birth Date (Mo. Day Yr.)
<input type="checkbox"/> Self					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single		
<input type="checkbox"/> Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single		
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single		
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single		
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single		

C. BENEFIT SELECTION -- CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

Elect or Waive Health (self)

Elect or Waive Health (dependents)

Health plan product name:

Alternate Plan 3 Aware Alternate Plan 4 Northeast

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

Signature of employee _____ Date signed _____

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee's date of employment (MM/DD/YY):	Employee's occupation:	Hours worked per week:
---	------------------------	------------------------

Monthly salary (complete only if applying for salary-based benefits): _____

Indicate the reason employee is enrolling for coverage:

- New employee Rehire (length of layoff): _____ New group
- Return from leave of absence (length of absence): _____
- Previously waived coverage Change from part-time to full-time
- Certificate of coverage termination Other: _____

Date of event: _____

Group numbers:

Health group #: _____ Health subgroup #: _____ Department #: _____

I certify the above information to be true and correct.

Signature: _____ Date: _____

Employer name:	Telephone number	Fax number
----------------	------------------	------------

E. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage? Yes No

If yes, you must complete the following (for Medicare, list both Part A and B effective dates):

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (single or family)	Effective date

If Medicare; check reason for entitlement Age Disability End-stage Renal Disease
 Disability End-stage Renal Disease

F. COVERAGE CHANGE INFORMATION -- CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTIONS A, B AND C

Adding dependents:	Date of event	Cancelling dependents:	Date of event
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (explain in details):	_____
<input type="checkbox"/> Marriage	_____	County: _____	
<input type="checkbox"/> Other	_____	Details: _____	

Loss of prior health and/or dental coverage:
Did you lose health coverage?: Yes No

<input type="checkbox"/> Other coverage voluntarily terminated	_____	<input type="checkbox"/> Address change	
<input type="checkbox"/> Group continuation (COBRA) period exhausted	_____	<input type="checkbox"/> Phone number change	
<input type="checkbox"/> Employer contribution for coverage terminated	_____	<input type="checkbox"/> Name change	
<input type="checkbox"/> Coverage terminated due to loss of eligibility	_____	Reason: _____	

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

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

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