Group Membership Application

BlueCross BlueShield of North Dakota

Blue Cross Blue Shield of North Dakota (BCBSND) is an independent licensee of the Blue Cross and Blue Shield Association.

Dental Service Corporation of North Dakota

Dental products and/or administrative services are offered independently by The Dental Service Corporation of North Dakota (DSC) and are not Blue Cross Blue Shield products and/or administrative services. DSC is solely responsible for its products and/or administrative services.

North Dakota Vision Services Incorporated

Vision products and/or administrative services are offered independently by North Dakota Vision Services, Incorporated (VSI) and are not Blue Cross Blue Shield products and/or administrative services. VSI is solely responsible for its products and/or administrative services.

Lincoln Mutual Life & Casualty Insurance Company

Lincoln Mutual Life (LML) is an independent licensee of the Blue Cross and Blue Shield Association.

DCN

29302710 Rev. 5-10

BPN________________

Please type or print in black ink. Press firmly.

Group Membership Application

GROUP ROLL 3847 -

1. APPLICANT'S INFORMATION

Last Name	First	M.I.	Social Security Number – –
Mailing Address		State in Which You Reside	Home Phone ( ) –
City	State	Zip Code	Work Phone ( ) –
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed (*Give date if changing Marital Status*) – –	Sex ☐ M ☐ F	**Birth Date** (*mm-dd-yy*) – –	
Applicant's Employer	Occupation		Average Number of Hours Worked Weekly
Employment Status and Date (*mm-dd-yy*) ☐ Full-time ☐ Part-time – –	**Requested Effective Date** (*mm-dd-yy*) – –		

2. SPOUSE/DEPENDENT INFORMATION *(Use extra paper if necessary)*

- List all family members to be covered, other than yourself. Indicate their relationship to you (i.e. child, stepchild, adopted, legal guardian, grandchild).
- Indicate dependent's address below dependent's name if the address is different from yours.
- **If Marital Status is Single and you are applying for coverage for your Eligible Dependent(s), you are required to attach a copy of the state birth certificate for each dependent unless previously submitted.**

☐ Yes ☐ No Are there any children under age 26 eligible to enroll under their own/spouse's employer health plan?

First Name M.I. Last (*if different*)	Relationship	Sex	Birth Date (*mm-dd-yy*)	Active Military	Married	Court Ordered Coverage	Social Security Number
	SPOUSE	☐ M ☐ F	– –	☐ Yes ☐ No	N/A	N/A	– –
Address:		☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –

3. COVERAGE INFORMATION

☒ 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.)

HEALTH (BCBSND) coverage *(if applicable)*:

☐ New Coverage (I do not have BCBSND coverage now)
☐ Change in Existing BCBSND Coverage
☐ I Refuse Coverage*

I am applying for:

☐ Single Coverage = myself only
☐ Single Plus Dependent Coverage = myself and eligible children
If married, is your spouse covered by an employer sponsored group health benefit plan? ☐ *Yes* ☐ *No If no, must apply for Family Coverage.*
☐ Family Coverage = myself and spouse **OR** myself, spouse and eligible children

Provider Network Name, if applicable: ________________

If applying for First Choice, you must complete an affiliation form.

DENTAL (DSC) coverage *(if applicable)*:

☐ New Coverage
☐ Change in Existing Coverage Not Applicable
☐ I Refuse Coverage*

I am applying for:

☐ Single Coverage = myself only
☐ Family Coverage° = myself and spouse **OR** myself, spouse and eligible children

°*(List all family members to be covered other than yourself in Section 2)*

VISION (VSI) coverage *(if applicable)*:

☐ New Coverage
☐ Change in Existing Coverage Not Applicable
☐ I Refuse Coverage*

I am applying for:

☐ Single Coverage = myself only
☐ Family Coverage° = myself and spouse **OR** myself, spouse and eligible children

°*(List all family members to be covered other than yourself in Section 2)*

GROUP LIFE (LML) coverage *(if applicable)*:

☐ Yes ☐ No* Basic Life (myself only) Not Applicable
☐ Yes ☐ No* Dependent Life
☐ Yes ☐ No* Supplemental Life $ __________

My annual salary is $ __________ Class __________

Primary Beneficiary Name __________

Relationship to Applicant __________

Contingent Beneficiary Name __________

Relationship to Applicant __________

DISABILITY (LML) coverage *(if applicable)*:

☐ Yes ☐ No* Short-Term Disability Not Applicable
☐ Yes ☐ No* Long-Term Disability

***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.

4. OTHER COVERAGE INFORMATION *(Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. FAILURE TO PROVIDE DOCUMENTATION MAY AFFECT YOUR WAITING PERIOD.)*

Other Health Benefit Plan including BCBSND coverage/Publicly Sponsored Program *(If you have other dental or vision coverage, provide information on a separate piece of paper.)*

☐Yes ☐No Are you, your spouse or any of your Eligible Dependents **currently** or **previously covered** by another health benefit plan(s)? If yes, please complete this section.

Other Coverage Name	Other Coverage Phone Number	Policy Number	Policyholder *(first, m.i., last name)*	Birth Date *(mm-dd-yy)* – –

Policy Coverage Dates *(mm-dd-yy)* From ___ – ___ – ___ to ___ – ___ – ___	Name(s) of Person(s) Covered

☐Yes ☐No Do you intend to keep your current policy in force after the effective date of this application? **If not, why?**_____

Medicare

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently or previously enrolled in Medicare? If yes, please complete this section.

Name(s) of Person(s) enrolled in Medicare	Medicare Claim Number *(include alpha characters as shown on Medicare card)*

Hospital Part A Effective Date ☐☐-0 1-☐☐	Medical Part B Effective Date ☐☐-0 1-☐☐	Prescription Drug Part D Effective Date ☐☐-0 1-☐☐

Workers' Compensation/No-Fault

☐Yes ☐No Are you, your spouse or any of your Eligible Dependents currently receiving or have received workers' compensation benefits?

☐Yes ☐No Are you, your spouse or any of your Eligible Dependents currently receiving or have received no-fault benefits?

Person's Name	Injury Date *(mm-dd-yy)* – –	Type of Injury	Company Providing Benefits	Company Phone Number

5. SIGNATURE(S) *(This form must be signed and dated)*

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 certify the information is accurate and complete. I understand and agree that any fraudulent act or intentional misrepresentation of material fact may void any Benefit Plan(s) issued based on 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 _____ X _____

Applicant's Signature **Date Signed** **Spouse's Signature (if to be insured)** **Date Signed**

Agent Number	**Agent Name**
Amount Received with App $_____ . ____	Voucher Number

DCN _____

WHITE ORIGINAL - BCBSND *YELLOW COPY - Employer* *WHITE COPY - Applicant*

If you have questions or require assistance when completing this application, please contact one of our offices listed below:

Home Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2227

Fargo District Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 282-1149

Grand Forks District Office
American Office Park
2810 19th Ave. S.
Grand Forks, ND 58201
Phone: (701) 795-5340

Dickinson Office
150 W. Villard, Suite 2
Dickinson, ND 58601
Phone: (701) 225-8092

Bismarck District Office
Tuscany Square
107 W. Main Ave.
Bismarck, ND 58501-2657
Phone: (701) 223-6348

Minot District Office
1600 S. Broadway
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

(800) 342-4718

www.BCBSND.com

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 3, Coverage Information).

BLUE SAVER BENEFIT PLAN

I understand the Blue Saver 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 Blue Saver 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.

LIFE INSURANCE BENEFITS

In the event of my death while insured, any death benefit payable under this coverage shall be paid in accordance with the beneficiary designation.

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.