BlueCross BlueShield Minnesota

Application For Individual/Family Plan Health Insurance

Please Complete Steps 1-7.

If you are an insurance agent/producer, please complete Steps 1-8.

Step 1) Tell us about yourself.

Step 2) Tell us about your household.

Step 3) Find your county and choose your plan. Before selecting a plan, make sure your provider is in-network for that plan. Not every provider is in every network, and not every plan is available statewide.

Step 4) Tell us if you have a special enrollment event.

Step 5) Tell us if you have other health insurance.

Step 6) Sign, authorize, and date your Application.

Step 7) Send your completed Application (all pages) and payment to Blue Plus.

Step 8) If you are an insurance agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.

Need Help?

This information is available in other ways to people with disabilities or who need it translated into another language by calling 1-800-382-2000 **(toll-free). For TTY, call 711.**

Need help choosing a plan or completing this Application?
For in-person help: Visit your local Blue Cross and Blue Shield of Minnesota and Blue Plus Retail Center
If you work with an insurance agent/producer: Please contact your Agent or Broker for assistance. **Or** call Blue Plus at 1-800-262-0823 and one of our representatives will be happy to assist you.
Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

During the open enrollment period, you can enroll online: https://www.bluecrossmnonline.com

General Information

- You must be a resident of Minnesota. You may obtain our Residency Policy at www.bluecrossmn.com/residencypolicy or at 1-800-262-0823 and one of our representatives will be happy to assist you.
- Individuals (whether you or any dependent) enrolled in or receiving benefits under Medicare Part A and/or Part B are not eligible to enroll in an individual commercial plan. If you enroll in a Blue Plus individual commercial plan, you must immediately notify Blue Plus if you (or any dependent) enroll in or obtain health insurance benefits under a Medicare program after submitting this Application or at any time during your period of coverage in the Blue Plus plan.
- If eligible, coverage will be provided under an individual contract. Blue Plus does not issue individual coverage through any arrangement with an employer.
- Please note, Blue Plus 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 Blue Plus 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 Blue Plus will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at 1-800-382-2000 before you complete this Application.

To submit your Application faster, please use one of these options to enroll:

- Online: https://www.bluecrossmnonline.com (during open enrollment period only)
- By telephone: 1-800-262-0823

General Information - continued

- Pediatric dental coverage is an essential health benefit available for purchase through a separate contract. For additional information on available pediatric dental plans, please visit www.mnsure.org. Pediatric dental benefit coverage is provided by an independent company.
- A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by calling one (1) of the telephone numbers listed on page 1.
- Please complete this entire Application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete Applications will be returned to you to be completed. This may affect the date your coverage starts. Sign and date this Application. This Application must be received at the home office of Blue Plus within 15 days of your signature. Incomplete Applications are null and void after 30 days.

STEP 1 - Tell Us About Yourself

☐ Open Enrollment ☐ Special Enrollment

I have an existing Blue Cross or Blue Plus ID# _____

I am a new applicant:

☐ Applying for coverage for myself only ☐ Applying for coverage for myself and my dependents

☐ Applying for coverage on behalf of my child(ren). If you are applying on behalf of a child under the age of 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child.

I am currently enrolled in a Blue Plus Individual Plan:

☐ Adding a dependent ☐ Making a plan change

Please note: Processing of your Application <u>may</u> be delayed if this form is NOT completed in its entirety*. PLEASE PRINT CLEARLY.

*Social Security Numbers (SSN) for you and your dependents are requested for benefit administration and reporting to the Internal Revenue Service (IRS) so you may demonstrate having minimum essential coverage and avoid having to pay a tax penalty. Please include SSN with your Application, however, it is not required.

First Name, Middle Name, Last Name & Suffix			
Social Security Number (If no SSN, write N/A)	Sex ☐ Male ☐ Female		Date of Birth *(mm/dd/yyyy)*
Permanent Home Address (No P.O. Box #)			Apartment Number
City	State	Zip Code	County
☐ Correspondence address (If different from home address)			Apartment Number
City	State	Zip Code	County
☐ Billing address (If different from permanent home and mailing address)			Apartment Number
City	State	Zip Code	County
E-mail address			
Home telephone number (non-mobile)	Work telephone number		Mobile telephone number

1. ☐ Yes ☐ No I am a permanent resident of Minnesota since:_____ *(mm/dd/yyyy)*
2. Will you or any other enrollee receive any premium or cost-sharing payments made by a specific person or entity, directly or indirectly, by an ineligible third-party described on page 1 above? ☐ Yes/Not sure ☐ No
3. Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

   If Yes, when was the last time you used tobacco regularly? _____ *(mm/dd/yyyy)*

GO TO STEP 2

STEP 2 - Tell Us About Your Household

Tell us about everyone who is applying for coverage.

Dependent 1 **Full Name (First, MI, Last)**	**Relationship to Applicant**	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**	**Sex**
				☐ Male ☐ Female

Does this person live at the same address as you? ☐ Yes ☐ No
If No, list address:

Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? _____
(mm/dd/yyyy)

Dependent 2 **Full Name (First, MI, Last)**	**Relationship to Applicant**	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**	**Sex**
				☐ Male ☐ Female

Does this person live at the same address as you? ☐ Yes ☐ No
If No, list address:

Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? _____
(mm/dd/yyyy)

Dependent 3 **Full Name (First, MI, Last)**	**Relationship to Applicant**	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**	**Sex**
				☐ Male ☐ Female

Does this person live at the same address as you? ☐ Yes ☐ No
If No, list address:

Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? _____
(mm/dd/yyyy)

Dependent 4 **Full Name (First, MI, Last)**	**Relationship to Applicant**	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**	**Sex**
				☐ Male ☐ Female

Does this person live at the same address as you? ☐ Yes ☐ No
If No, list address:

Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? _____
(mm/dd/yyyy)

Dependent 5 **Full Name (First, MI, Last)**	**Relationship to Applicant**	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**	**Sex**
				☐ Male ☐ Female

Does this person live at the same address as you? ☐ Yes ☐ No
If No, list address:

Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? _____
(mm/dd/yyyy)

☐ Additional dependent(s) on attached page

GO TO STEP 3

STEP 3 - Choose Your Plan

Find your county and choose your plan. Before selecting a plan, make sure your provider is in-network for that plan. Not every provider is in every network, and not every plan is available statewide.

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

For plans with more than one person (family plan), no one member will exceed the single in-network deductible amount listed below. Also, eligible costs incurred by all covered family members count toward satisfying the family in-network deductible.

I am/we are applying for coverage under:

Blue Plus Western MN - Single/Family Plans

Available for residents in the following counties: Becker, Beltrami, Big Stone, Cass, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, Mahnomen, Marshall, Murray, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rock, Stevens, Swift, Traverse, Wadena, Wilkin, Yellow Medicine

Network: Blue Plus Western MN

80% Plan
- ☐ $900/$2,700 Plan 251

85% Plan
- ☐ HSA $3,500/$10,500 Plan 250

100% Plan
- ☐ HSA $6,650/$13,300 Plan 257

Blue Plus Northeast MN - Single/Family Plans

Available for residents in the following counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, Pine, Saint Louis

Network: Blue Plus Northeast MN

80% Plan
- ☐ $900/$2,700 Plan 282

85% Plan
- ☐ HSA $3,500/$10,500 Plan 281

100% Plan
- ☐ HSA $6,650/$13,300 Plan 280

Blue Plus Metro MN - Single/Family Plans

Available for residents in the following counties: Anoka, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, McLeod, Nicollet, Ramsey, Scott, Sherburne, Sibley, Washington, Wright

Network: Blue Plus Metro MN

80% Plan
- ☐ $900/$2,700 Plan 254

85% Plan
- ☐ HSA $3,500/$10,500 Plan 253

100% Plan
- ☐ HSA $6,650/$13,300 Plan 258

Blue Plus Southeast MN - Single/Family Plans

Available for residents in the following counties:
Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan, Winona

Network: Blue Plus Southeast MN

80% Plan
- ☐ $900/$2,700 Plan 272

85% Plan
- ☐ HSA $3,500/$10,500 Plan 271

100% Plan
- ☐ HSA $6,650/$13,300 Plan 270

The deductible, copay and out-of-pocket maximum amounts are subject to annual adjustments.

GO TO STEP 4

STEP 4 - Special Enrollment

A Special Enrollment Period is defined as a period during which you and your family have a right to sign up for new or make changes to existing health coverage. Special Enrollment Period qualifying life events include, but are not limited to, certain permanent moves, certain changes in your income and changes in your family size (such as if you marry, birth or adoption) or a loss of coverage. If you are enrolled in a plan that counts as minimum essential coverage in most instances consumers have 60 days from the occurrence of the qualifying life event to sign up for or make changes to existing coverage; however there are some instances defined in the chart below that allow 60 days before and after a qualifying life event to sign up for or make changes to existing coverage.

This Special Enrollment Period section within this Application CANNOT be used to make changes to coverage purchased from MNsure or to purchase new coverage from MNsure. To make such changes or purchases, you must contact MNsure directly.

If you would like to enroll or change plans due to a qualifying life event, you must complete this Special Enrollment section and include or attach any necessary supporting documents. Select the appropriate qualifying life event below. The listing of qualifying life events is subject to change. If you do not see the qualifying event that describes your situation, please contact us at 1-800-262-0823.

All materials, including supporting document(s), must be provided before coverage will begin. Failure to provide all materials, including any supporting documents (listed below) to prove eligibility, may delay your Application or cause you to be denied coverage.

Date of Event: _____

Qualifying Life Event	Coverage effective date	Supporting Documents
❑ Birth ❑ Adoption ❑ Placed for Adoption ❑ Placed in Foster Care ❑ Court Order	Date of birth, adoption, placement for adoption or foster care OR the first day of the month following the event date. For court order, date the order is effective or if plan selection is between 1st and 15th of the month, your coverage will start on the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event. Effective date requested:_____	❑ Birth Certificate ❑ Existing Blue Cross or Blue Plus member with proof of claims for birth ❑ Legal papers for Adoption or Foster Care ❑ Court Order
❑ Marriage. You or your spouse must have had minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage; unless you have an eligible exception.	First day of the month following plan selection. The coverage effective date cannot be prior to the occurrence of the event.	❑ Proof from prior carrier of minimum essential coverage ❑ Marriage certificate
❑ Release from incarceration ❑ Return from active military service	If the plan selection is between the 1st and 15th of the month, your coverage will start as soon as the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event.	❑ Prison release form ❑ Supporting paperwork confirming departure date from active military service
❑ A permanent move to a new area that offers different health plan options. You must have had minimum essential coverage (MEC) for 1 or more days during the 60 days preceding the permanent move; unless you have an eligible exception. Documentation confirming move and prior MEC are required.	If the plan selection is between the 1st and 15th of the month, your coverage will start as soon as the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event.	❑ Proof from prior carrier of minimum essential coverage ❑ Proof of new residence such as dated rental/lease agreement, deed, purchase agreement, new driver's license or state photo ID card. ❑ Notice from carrier no longer providing health coverage ❑ A utility bill in the applicant's name and containing the new address

GO TO STEP 4 Continued

STEP 4 - Special Enrollment - continued

Qualifying Life Event	Coverage effective date	Supporting Documents
❑ A change in income, household or other status that affects eligibility for Advance Premium Tax Credits (APTC) or Cost-sharing Reductions (CSR). Must currently be enrolled in a Qualified Health Plan.	If the plan selection is between the 1st and 15th of the month, your coverage will start as soon as the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event.	❑ Copy of MNsure eligibility notice
❑ Loss of pregnancy related or medically needy coverage under Medicaid. ❑ Loss of Minimum Essential Coverage (includes but not limited to): - Loss of eligibility for employer sponsored coverage due to job loss or reduction in hours - Employer no longer offers benefits or closes - Legal separation/Divorce from policy holder - Employee/policy holder becomes Medicare entitled - Death of policy holder - Child loses dependent status - Loss of eligibility for Medicaid, MinnesotaCare or CHIP - Expiration of COBRA or non-calendar year policy - Moving out of existing ACO or HMO plan service area	Notification can be 60 days prior to and 60 days after the loss of coverage. If plan selection is before or on the date of loss of coverage the effective date is the first day of the month following the loss of coverage. If plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection. Coverage effective date cannot be prior to the occurrence of the event. *NOTE: Voluntarily quitting other health coverage or being terminated for not paying premiums are not considered losses of minimum essential coverage. Losing health coverage that is not minimum essential coverage is also not considered a loss of minimum essential coverage.*	Documentation showing loss of medically needy coverage or Minimum Essential Coverage, including: • Termination Date • People covered by the plan ❑ Letter of termination from carrier (includes dependent age max reached) ❑ Notice of termination of government sponsored coverage ❑ Letter/notice of termination of benefits from the employer (includes divorce from policy holder, death of policy holder or policy holder becomes Medicare entitled) ❑ COBRA eligibility notice or documentation showing that COBRA coverage or non-calendar year policy is ending ❑ Letter of termination from carrier/ insurance company and proof of address change
❑ Determined to be newly eligible for Advance Premium Tax Credit (APTC) due to not being eligible for coverage by an eligible employer sponsored plan *APTC is only available through MNsure	Notification can be 60 days prior to and 60 days after the loss of coverage. If plan selection is before or on the date of loss of coverage the effective date is the first day of the month following the loss of coverage. If plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection. Coverage effective date cannot be prior to the occurrence of the event.	❑ Copy of MNsure eligibility notice
❑ MNsure determined that an unintentional enrollment error is the result of an action or omission by an agent of MNsure or Non-Exchange Entity. ❑ MNsure determines that there has been a violation of a material provision of the health plan in which you or a dependent are enrolled. Must currently be enrolled in a Qualified Health Plan.	Coverage effective date will be determined by MNsure. You must send in the necessary supporting documentation from MNsure along with this form and a completed Application.	❑ Copy of MNsure eligibility notice

GO TO STEP 5

STEP 5 - Tell Us About Other Health Insurance Information

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ☐ Yes ☐ No
2. Will you or any dependent(s) named on this Application be eligible for Medicare Part A or enrolled in Medicare Part B or both? ☐ Yes ☐ No
3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Blue Cross or Blue Plus policy. If you have a current individual/family policy, your current policy will generally be replaced as of the effective date of your new plan unless your current coverage is through an employer or purchased through *MNsure. ☐ Yes ☐ No

If Yes, to any question above, complete question 4. **If No,** skip question 4 and go to the next section.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

Name of Insurance Carrier or Governmental Plan: _____ Group Number: _____

Name of Policy Holder: _____ Effective Date: _____

Policy Number: _____ Relationship to Applicant: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employment Status: _____

*If you have coverage purchased through MNsure, you must contact MNsure to terminate the coverage.

Effective Date of Coverage

During the Open Enrollment Period: January 1, 2018, if the Application is received on or before December 15, 2017.

Your coverage may not take effect until we receive your first premium payment. Failure to pay by the due date on your first invoice could delay your effective date.

REMITTANCE SLIP

Please complete the Remittance Slip to pay your first month's premium. (Note: You may be required to pay any past due premiums for previous Blue Plus coverage due during the 12-month period preceding the effective date of this coverage.) If you do not complete the Remittance Slip, you will be billed separately for your first month's premium. *Note:* If you are a current Blue Plus member signed up to use Pay It Easy, your first month's premium under your new plan may not be automatically debited from your account, and you may need to complete and submit a new Pay It Easy form for your recurring payment.

Policyholder Name (First, Middle, Last): _____

Telephone Number: _____ Zip Code: _____ Social Security Number: _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____ Plan Number (see page 4): _____

If you plan to fax/e-mail your Application, mail in this page with your first month payment. Failure to do so may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 9.

Applicant's Last Name	**First Name**

GO TO STEP 6

STEP 6 - Sign, Authorize and Date Application

My/our signature on this Application indicates that I/we have read and fully understand the following statements when applying for health coverage through Blue Cross and Blue Shield of Minnesota and/or Blue Plus (Blue Plus): I understand and agree that coverage, if approved, will begin as specified on page 7. I authorize Blue Plus either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Plus uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Plus receives my check and I will not receive my check back from my financial institution.

I understand that the health plan I have selected contains 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 Maximum).

I understand that coverage will be provided under an individual contract. I understand that Blue Plus does not issue individual coverage through any arrangement with an employer. Blue Plus is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

For purposes of obtaining information in connection with this Application, reinstatement, or change in policy benefits, this release is valid as long as I am continually covered with Blue Plus. I am entitled to receive a copy of any release I sign. I agree if I am enrolling in a product that features certain designated providers, Blue Plus may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

Blue Plus primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the applicant and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the Application, even if I and/or dependent(s) listed on this Application currently have coverage or had prior coverage with Blue Plus. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota at the permanent home address listed in step 1 and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Plus will rescind my contract and coverage, and no claims will be paid. I further attest that I was not encouraged or advised to apply for this coverage in connection with any offer by an "ineligible third party" (described on page 1) to directly or indirectly pay all or some of my premiums or cost-sharing.

I understand and agree that payment of a claim does not preclude the right of Blue Plus 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 this plan does not include coverage for the pediatric dental essential health benefit and that Blue Plus has made me aware of pediatric dental coverage available for purchase through a separate contract.

I agree to notify Blue Plus immediately of any change in my (or my dependent(s)) enrollment information contained in this Application or otherwise provided. Failure to notify Blue Plus of any change in the information contained in this Application or otherwise provided may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning my eligibility or any dependent(s) eligibility enrolling for coverage. 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 Blue Plus will act in reliance upon the information I have provided on this Application which materially affects enrollment eligibility and may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

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

By providing your telephone 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 Blue Plus 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 e-mail or text message from an unsecured e-mail or device, Blue Plus 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 understand that this Agreement renews on an annual basis. I acknowledge that if my first payment is not made with this Application, premium payment is required by the due date printed on my first invoice. I understand that failing to pay before this due date will result in my Application being voided. I understand that payments in advance of the monthly amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received.

GO TO STEP 6 Continued

STEP 6 - Sign, Authorize and Date Application - continued

I acknowledge that if my on-going monthly premium payments are not received within the plan grace period, my plan will be terminated. I understand that nothing in this Application creates a contract, and that, if this Application is approved, coverage will not take effect until I have made my first premium payment. I understand that the date I pay my first premium may impact my desired effective date.

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

Applicant's Signature _____ Date _____

Spouse/Domestic Partner/Parent's Signature _____ Date _____

This Application Is Valid Only When Completed and Signed By The Applicant/Parent (if applying for a child under age 18).

STEP 7 - Send Your Completed Application and Payment to Blue Plus

Send in your completed Application and payment to Blue Plus by one of the following methods.

U.S. Mail:

Include your completed, signed Application along with your first premium payment to:
Blue Plus
P.O. Box 64024
St. Paul, MN 55164

Fax or e-mail:

Fax your completed, signed Application to 651-662-6439 or e-mail to enrollment.forms@bluecrossmn.com -- *and* -- mail your first premium payment with completed remittance slip to:
Blue Plus
P.O. Box 64024
St. Paul, MN 55164

Drop Your Application and Payment Off In Person At Your Local Blue Cross and Blue Shield of Minnesota and Blue Plus Retail Center:

For locations, please visit www.bluecrossmn.com or call 1-800-382-2000.
You may also visit bluecrossmn.com/centers to make an appointment near you.

Please Note: This Agreement renews on an annual basis. You can pay your premium monthly in advance to Blue Plus. If it is convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis during the calendar year. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Please note: Processing of your Application may be delayed if this Application is NOT completed in its entirety. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to your situation, please mark as 'N/A'.

Step 8 - For Producer Use Only

PRODUCER'S CERTIFICATE

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-800-262-0821.

If this section is not fully completed, we will not pay a commission.

Blue Cross Blue Shield Agency No.							Producer No.						

A PRODUCER must complete this section to act on the applicant's behalf.

I certify that I have met the requirements listed in Minnesota Statute 60K.46 subdivision 4 regarding suitability, as well as those requirements set forth in the Agent Code of Conduct and within the Blue Cross and Blue Shield of Minnesota and Blue Plus contractual agreement. I further understand, no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy or waive Blue Cross and Blue Shield of Minnesota's and/or Blue Plus' rights or requirements.

It is your responsibility as a producer to retain a signed copy of this Application for your records.

Agency Name _____

Producer's Name _____
LAST *FIRST* *MI*

Producer's Signature _____

Business Telephone _____

BlueCross BlueShield Minnesota

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

Blue Cross Blue Shield of Minnesota and Blue Plus
3535 Blue Cross Road
Eagan, MN 55122

INTERNAL USE ONLY

Blue Cross Blue Shield Agency No.							Producer No.						

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.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကွ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫíóąǫąęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

image_0002R01_General_Portrait (09/16)

Thông báo này có thông tin quan trọng về đơn đăng ký hoặc phạm vi bao trả theo chương trình sức khỏe của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì phạm vi bao trả hoặc được giúp đỡ có tính phí. Nếu quý vị, hoặc người quý vị đang giúp đỡ, có thắc mắc về thông báo này hoặc phạm vi bao trả theo chương trình sức khỏe của quý vị, quý vị có thể nhận giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 1-855-315-4015 (miễn phí). Người dùng TTY xin gọi 711.

Beeksis kun waayee iyyannoo keetii ykn kan karoorri fayyaa kee qabaachuu malu odeeffannoo barbaachisaa qaba. Guyoota futuu ta'an achi keessa ilaali. Insuraansiin kee akka addaan hincinnee fi basii tokko tokkoof gargaarsa argachuudhaaf, yeroon utuu itti hindarbin tarkaanfii fudhachuu qabda. Ati ykn nami ati gargaaraa jirtu yoo waayee beeksisakana ykn karoora fayyaa kana kee hanga inni ga'u gaaffii qabaattan, kaffaltii malee gargaarsaa fi odeeffannoo afaan keessaniin argachuu dandeessu. Nama afaan isinii hiiku waliin haasa'uudhaaf 1-855-315-4016 (lak. Tolaa bilbila'a). TTY dhaaf, 711 bilbilaa.

本通知包含與您申請或健康計劃承保有關的重要資訊。請注意本通知中的重要日期。您可能需要在特定期限之前採取行動才能維持承保或取得費用補助。如果您本人或您協助的對象對本通知或健康計劃承保有疑問，您可免費以您的語言取得協助和資訊。如欲與口譯員交談，請致電 1-855-315-4017（免費電話）。聽語障專線 (TTY)，請撥打 711。

В этом уведомлении содержится важная информация о Вашей заявке на включение в план или страховом покрытии, предоставляемом планом медицинского страхования. Обратите внимание на даты, приведенные в этом уведомлении. Для того чтобы сохранить страховку или получить помощь в связи с какими-либо выплатами, Вам, возможно, потребуется к определенному сроку предпринять какие-то действия. Если у Вас или у кого-то, кто Вам помогает, появятся вопросы по поводу этого уведомления или предоставляемого планом страхового покрытия, Вы можете бесплатно получить помощь и информацию на Вашем родном языке. Чтобы связаться с переводчиком, позвоните по телефону 1-855-315-4028 (звонки бесплатные). Для использования телефонного аппарата с текстовым выходом звоните 711.

Cet avis contient des informations importantes concernant votre application ou votre assurance maladie. Recherchez les dates-clés dans cet avis. Il se peut que vous deviez réagir avant certaines dates limites pour conserver votre couverture ou recevoir une aide pour vos frais. Si vous-même ou la personne que vous aidez avez des questions concernant cet avis ou l'assurance maladie, vous pouvez recevoir de l'aide et des informations dans votre langue gratuitement. Pour parler à un interprète, appelez le 1-855-315-4029 (appel gratuit). Pour les personnes malentendantes, appelez le 711.

ይህ ማስታወቂያ ማመልከቻዎን ወይም የጤና ዕቅድ ሽፋንዎን በተመለከተ አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ዋናዋና የሆኑ ቀናትን ይመልከቱ። የእርስዎ የጤና እቅድ ሽፋን እንዲቀጥል ወይም ዋጋው በሚመለከት እርዳታ ለማግኘት በተወሰኑ ቀነ ገደቦች እርምጃ መውሰድ ይኖርብዎቷል። እርስዎ ወይም እርስዎ የሚረዱት ሰው ይህን ማስታወቂያ ወይም የጤና እቅድ ሽፋን በሚመለከት ጥያቄ ካላችሁ፤ ምንም ወጪ ሳታወጡ በራሳችሁ ቋንቋ እርዳታ እና መረጃ ማግኘት ትችላላችሁ። ከአስተርጓሚ ጋር ለመነጋገር በስልክ ቁጥር 1-855-315-4030 (በነጻ) ይደውሉ። ይደውሉ ለ TTY በ 711።

본 통지서에는 귀하의 보험 가입이나 의료 보험 적용 범위에 대한 중요한 정보가 담겨 있습니다. 본 통지서에 나와 있는 중요한 날짜를 확인해 보십시오. 귀하께서는 특정 마감 기한까지 조치를 취하셔야 계속 보험 적용을 받거나 비용 지원을 받으실 수 있습니다. 귀하 본인이나 귀하가 도와주고 있는 사람이 본 통지서나 의료 보험 적용 범위에 대한 질문이 있는 경우, 본인 비용 부담 없이 모국어로 지원 및 정보를 받으실 수 있습니다. 통역사와 통화를 하시려면, 1-855-904-2583 번(수신자 부담)으로 연락하시기 바랍니다. 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງໃນແຜນປະກັນສຸຂະພາບຂອງທ່ານ. ຊອກເບິ່ງວັນທີສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານໄວ້ ຫຼື ເພື່ອຮັບເອົາການຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍ. ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບແຈ້ງການນີ້ ຫຼື ຄວາມຄຸ້ມຄອງໃນແຜນປະກັນສຸຂະພາບ, ທ່ານສາມາດຮັບເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-866-356-2423 (ບໍ່ໂທເກັບເງິນປາຍທາງ). ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw ng planong pangkalusugan. Maghanap ng mahahalagang petsa sa paunawang ito. Maaaring kailanganin mong gumawa ng aksyon sa pamamagitan ng ilang mga itinakdang panahon upang mapanatili ang iyong saklaw o makatanggap ng tulong para sa mga gastos. Kung ikaw, o ang isang tao na tinutulungan mo, ay may mga katanungan tungkol sa paunawang ito o saklaw ng planong pangkalusugan, makatatanggap ka ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang taga-interpret, tumawag sa 1-866-537-7720 (walang bayad ang toll). Para sa TTY, tumawag sa 711.

Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder zur Abdeckung durch Ihren Gesundheitsschutzplan. Beachten Sie wichtige Daten in dieser Mitteilung. Sie müssen unter Umständen innerhalb gewisser Fristen bestimmte Handlungen ergreifen, damit Ihre Abdeckung bestehen bleibt oder Sie Kostenunterstützung erhalten. Wenn Sie oder eine Person, die Ihnen zur Seite steht, Fragen zu dieser Mitteilung oder zur Abdeckung durch den Gesundheitsschutzplan haben, können Sie kostenlos Hilfe und Informationen in Ihrer Muttersprache erhalten. Um mit einem Dolmetscher zu sprechen, wählen Sie 1-866-289-7402 (gebührenfrei). Für TTY wählen Sie 711.

កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់អំពីការដាក់ពាក្យ ឬការគ្របដណ្តប់នៃគម្រោងសុខភាពរបស់អ្នក។ រកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងកំណត់សម្គាល់នេះ។ អ្នកអាចត្រូវការចាត់វិធានការត្រឹមកាលបរិច្ឆេទផុតកំណត់ជាក់លាក់នានាដើម្បីរក្សាការគ្របដណ្តប់របស់អ្នក ឬដើម្បីទទួលបានជំនួយជាមួយថ្លៃចំណាយផ្សេងៗ។ ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពីកំណត់សម្គាល់នេះ ឬការគ្របដណ្តប់នៃគម្រោងសុខភាព អ្នកអាចទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែផ្ទាល់មាត់ សូមទូរស័ព្ទទៅលេខ 1-855-906-2583 (លេខឥតគិតថ្លៃ)។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Díí éí nits'íís baa áháyą́ binaaltsoos dóó bee nik'i adéest'i'ígí aláahgo binahjį' ééhózinígí át'é. Yoołkáál dabiká'ígí baa ákonínízin dooleeł. Łahda t'áadoo áajį' iiłkááhí éí díí naaltsooshazhdiil'íįh díí shá bik'é azláadoo jinízingo. Ni éí doodagóó t'áá háída biká'anilyeedígí díí naaltsoos dóó bik'é azláhígí bąąh na'ídíkid neehólǫǫgo éí t'áájíík'e t'áá nizaad k'ehjí bee niłhodoonih dóó niká'adoolwołgo éí át'é. Ata' halne'é ła' bichį' hadeesdzih nínízingo éí 1-855-902-2583 jį't'áá jíík'e béésh bee hodíílnih. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.