



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

Application For Individual/Family Plan Health Insurance

Please Complete Steps 1– 9.

- Step 1)** Tell us about yourself.
- Step 2)** Tell us about your household.
- Step 3)** Choose a plan.
- Step 4)** Tell us if you have a special enrollment event.
- Step 5)** Tell us if you have other health insurance.
- Step 6)** Review Notification and Authorization.
- Step 7)** Review Payment and Billing Information.
- Step 8)** Sign the Application.
- Step 9)** Send your completed Application (all pages) and payment to Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus).

If this Application is being completed by an insurance agent/producer, please complete and return the Producer Attestation 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/producer 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>.
- **Eligible for a Subsidy?** If you're eligible for a subsidy, you can buy a health plan from us on MNsure, Minnesota's online health insurance marketplace. See if you qualify at www.mnsure.org.

Who Can Enroll in the Products on this Application?

- You must be a resident of Minnesota. You may obtain our Residency Policy at www.bluecrossmn.com or at 1-800-262-0823 and one of our representatives will be happy to assist you.
- Applicants (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.
- 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 above.

? Who Can Pay My Premium?

- Generally, you can pay your own premium.
- 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.

? How Do I Submit This Application?

- 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. The Applicant and Spouse/Domestic Partner, if applicable, must sign and date this Application. For Child Only, the Parent/Guardian applying on behalf of the child must sign. 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.
- 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

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 may 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. 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)		Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Permanent Home Address (No P.O. Box #)					
City		State	Zip Code	County	
Correspondence Address (If different)		Street	City	State	Zip Code
Billing address (If different)		Street	City	State	Zip Code
E-mail address					

You only need to provide one telephone number below:

Home telephone number (non-mobile)

Work telephone number

Mobile telephone number

STEP 1 - Tell Us About Yourself - continued

1. Yes No I am a permanent resident of Minnesota since: (mm/dd/yyyy) _____
If no, we can only offer coverage to permanent Minnesota residents. Refer to <https://healthcare.gov> for options in your State.
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 2 above? Yes/Not sure No
3. Do you have an Individual Coverage Health Reimbursement Arrangement (ICHRA) through your employer? Yes No
 If Yes, your employer is required to complete an ICHRA Employer Attestation form.
4. Do you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) through your employer? Yes No
 If Yes, your employer is required to complete an QSEHRA Employer Attestation form.
5. For Applicants 21 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) _____

STEP 2 - Who Will Be On The Plan?

This section should be used to list all dependents applying for coverage.

Dependent 1		Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name					
Middle Name					
Last Name					<input type="checkbox"/> Male <input type="checkbox"/> Female
Does this dependent live at the same address as the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No , list address:					
For dependents 21 years of age or older, has this dependent 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , when was the last time this dependent used tobacco regularly? (mm/dd/yyyy) _____					
Dependent 2		Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name					
Middle Name					
Last Name					<input type="checkbox"/> Male <input type="checkbox"/> Female
Does this dependent live at the same address as the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No , list address:					
For dependents 21 years of age or older, has this dependent 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , when was the last time this dependent used tobacco regularly? (mm/dd/yyyy) _____					
Dependent 3		Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name					
Middle Name					
Last Name					<input type="checkbox"/> Male <input type="checkbox"/> Female
Does this dependent live at the same address as the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No , list address:					
For dependents 21 years of age or older, has this dependent 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , when was the last time this dependent used tobacco regularly? (mm/dd/yyyy) _____					
Dependent 4		Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name					
Middle Name					
Last Name					<input type="checkbox"/> Male <input type="checkbox"/> Female
Does this dependent live at the same address as the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No , list address:					
For dependents 21 years of age or older, has this dependent 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , when was the last time this dependent used tobacco regularly? (mm/dd/yyyy) _____					
Dependent 5		Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name					
Middle Name					
Last Name					<input type="checkbox"/> Male <input type="checkbox"/> Female
Does this dependent live at the same address as the Primary Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No , list address:					
For dependents 21 years of age or older, has this dependent 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , when was the last time this dependent used tobacco regularly? (mm/dd/yyyy) _____					

Additional dependent(s) on attached page

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. **Find a Doctor:** <https://www.bluecrossmnonline.com>

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:

<p>Blue Plus Metro MN - Single/Family Plans</p> <p>Available for residents in the following counties: Anoka, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, McLeod, Nicollet, Ramsey, Scott, Sherburne, Sibley, Washington, Wright</p> <p>Network: Blue Plus Metro MN</p> <p>Gold 20% Plan <input type="checkbox"/> \$1,400/\$4,200 Plan 254</p> <p>Silver 30% HSA Plan <input type="checkbox"/> \$2,800/\$8,400 Plan 253</p> <p>Bronze 0% HSA Plan <input type="checkbox"/> \$7,050/\$14,100 Plan 258</p>	<p>Blue Plus Southeast MN - Single/Family Plans</p> <p>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</p> <p>Network: Blue Plus Southeast MN</p> <p>Gold 20% Plan <input type="checkbox"/> \$1,400/\$4,200 Plan 272</p> <p>Silver 30% HSA Plan <input type="checkbox"/> \$2,800/\$8,400 Plan 271</p> <p>Bronze 0% HSA Plan <input type="checkbox"/> \$7,050/\$14,100 Plan 270</p>
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<p>Blue Plus Minnesota Value - Single/Family Plans</p> <p>Available for residents in the following counties: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Douglas, Grant, Hennepin, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Lincoln, Lyon, Mahnommen, Marshall, McLeod, Meeker, Mille Lacs, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rock, Roseau, Scott, Sherburne, Sibley, St. Louis, Stearns, Stevens, Swift, Todd, Traverse, Wadena, Washington, Wilkin, Wright, Yellow Medicine</p> <p>Network - Blue Plus Minnesota Value</p> <table border="0"> <tr> <td data-bbox="89 1354 789 1671"> <p>Gold 20% Copay Plan <input type="checkbox"/> \$1,000/\$3,000 Plan 205</p> <p>20% Plan <input type="checkbox"/> \$1,400/\$4,200 Plan 202</p> <p>Silver 25% Copay Plan <input type="checkbox"/> \$3,000/\$9,000 Plan 204</p> <p>30% HSA Plan <input type="checkbox"/> \$2,800/\$8,400 Plan 201</p> </td> <td data-bbox="829 1354 1529 1671"> <p>Bronze 30% Copay Plan <input type="checkbox"/> \$6,000/\$12,000 Plan 203</p> <p>0% HSA Plan <input type="checkbox"/> \$7,050/\$14,100 Plan 200</p> </td> </tr> </table>		<p>Gold 20% Copay Plan <input type="checkbox"/> \$1,000/\$3,000 Plan 205</p> <p>20% Plan <input type="checkbox"/> \$1,400/\$4,200 Plan 202</p> <p>Silver 25% Copay Plan <input type="checkbox"/> \$3,000/\$9,000 Plan 204</p> <p>30% HSA Plan <input type="checkbox"/> \$2,800/\$8,400 Plan 201</p>	<p>Bronze 30% Copay Plan <input type="checkbox"/> \$6,000/\$12,000 Plan 203</p> <p>0% HSA Plan <input type="checkbox"/> \$7,050/\$14,100 Plan 200</p>
<p>Gold 20% Copay Plan <input type="checkbox"/> \$1,000/\$3,000 Plan 205</p> <p>20% Plan <input type="checkbox"/> \$1,400/\$4,200 Plan 202</p> <p>Silver 25% Copay Plan <input type="checkbox"/> \$3,000/\$9,000 Plan 204</p> <p>30% HSA Plan <input type="checkbox"/> \$2,800/\$8,400 Plan 201</p>	<p>Bronze 30% Copay Plan <input type="checkbox"/> \$6,000/\$12,000 Plan 203</p> <p>0% HSA Plan <input type="checkbox"/> \$7,050/\$14,100 Plan 200</p>		

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

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. Supporting documents must include, but not limited, to date of change or termination and everyone that will be covered by the plan. See Supporting Documents below for additional required information.

Date of Event: _____

Qualifying Life Event	Coverage effective date Note: The coverage effective date cannot be prior to the occurrence of the event.	Supporting Documents
<input type="checkbox"/> Loss of pregnancy related or medically needy coverage under Medicaid. <input type="checkbox"/> Loss of Minimum Essential Coverage (MEC) (includes but not limited to): <ul style="list-style-type: none"> <input type="checkbox"/> Loss of eligibility for employer sponsored coverage due to job loss or reduction in hours <input type="checkbox"/> Employer no longer offers benefits or closes <input type="checkbox"/> Legal separation/Divorce from policy holder <input type="checkbox"/> Employee/policy holder becomes Medicare entitled <input type="checkbox"/> Death of policy holder <input type="checkbox"/> Child loses dependent status <input type="checkbox"/> Loss of eligibility for Medicaid, MinnesotaCare or CHIP <input type="checkbox"/> Expiration of COBRA or non-calendar year policy <input type="checkbox"/> 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. <ul style="list-style-type: none"> • If the 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 the plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection <p>NOTE: <i>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.</i></p>	Documentation showing loss of medically needy coverage or MEC, including: <ul style="list-style-type: none"> • Termination Date • People covered by the plan • Reason for Termination <input type="checkbox"/> Letter of termination from carrier (includes dependent age max reached) <input type="checkbox"/> Notice of termination of government sponsored coverage <input type="checkbox"/> Letter/notice of termination of benefits from the employer (includes divorce from policy holder, death of policy holder or policy holder becomes Medicare entitled) <input type="checkbox"/> COBRA eligibility notice or documentation showing that COBRA coverage or non-calendar year policy is ending <input type="checkbox"/> Letter of termination from carrier/ insurance company and proof of address change
<input type="checkbox"/> 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.	<ul style="list-style-type: none"> • If the plan selection is between 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 	<input type="checkbox"/> Proof from prior carrier of MEC. <input type="checkbox"/> Proof of new residence such as dated rental/lease agreement, deed, purchase agreement, new driver's license or state photo ID card. <input type="checkbox"/> Notice from carrier no longer providing health coverage. <input type="checkbox"/> A utility bill in the applicant's name and containing the new address.
<input type="checkbox"/> Marriage. You or your spouse must have had minimum essential coverage (MEC) 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 the plan selection.	<input type="checkbox"/> Proof from prior carrier of MEC. <input type="checkbox"/> Marriage Certificate

STEP 4 - Special Enrollment - continued

Qualifying Life Event	Coverage effective date Note: The coverage effective date cannot be prior to the occurrence of the event.	Supporting Documents
<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Placed for Adoption <input type="checkbox"/> Placed in Foster Care <input type="checkbox"/> Court Order	<input type="checkbox"/> Date of qualifying life event OR <input type="checkbox"/> The first day of the month following the plan selection	<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Existing Blue Cross or Blue Plus Member with proof of claims for birth <input type="checkbox"/> Legal papers for Adoption or Foster Care <input type="checkbox"/> Court Order
<input type="checkbox"/> Release from incarceration <input type="checkbox"/> Return from active military service	<ul style="list-style-type: none"> • If the plan selection is between the 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 	<input type="checkbox"/> Prison release form <input type="checkbox"/> Supporting paperwork confirming departure date from active military service
<input type="checkbox"/> A change in income, household or other status that affects eligibility for Advance Premium Tax Credit (APTC)* or Cost-sharing Reductions (CSR). Must currently be enrolled in a Qualified Health Plan.	<ul style="list-style-type: none"> • 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 	<input type="checkbox"/> Copy of MNsure eligibility notice
<input type="checkbox"/> 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. <ul style="list-style-type: none"> • If the 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 the plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection 	<input type="checkbox"/> Copy of MNsure eligibility notice
<input type="checkbox"/> Determined that an unintentional enrollment error is the result of an action or omission by an agent of MNsure or Non-Exchange Entity.	Coverage effective date will be determined by MNsure. <ul style="list-style-type: none"> • You must send in the necessary supporting documentation from MNsure along with this form and a completed Application 	<input type="checkbox"/> Copy of MNsure eligibility notice
<input type="checkbox"/> 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. <ul style="list-style-type: none"> • You must send in the necessary supporting documentation from MNsure along with this form and a completed Application 	<input type="checkbox"/> Copy of MNsure eligibility notice
<input type="checkbox"/> Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	Individuals who are employed by a small employer at the time their small employer initially offers a QSEHRA plan shall have 30 days from the date the plan was initially offered to them to enroll in an individual plan. OR Newly hired individuals whose small employer offers a QSEHRA plan shall have 30 days after the first day of employment to enroll in an individual plan. Effective Dates: <ul style="list-style-type: none"> • If the plan selection is between the 1st and the 15th of the month, the effective date is the 1st of the following month • If the plan selection is between the 16th and the last day of the month, the effective date is the 1st of the second following month 	<input type="checkbox"/> QSEHRA Form from Employer
<input type="checkbox"/> Individual Coverage Health Reimbursement Arrangement (ICHRA)	Individuals who have health reimbursement arrangement through their employer shall have 60 days from the date the ICHRA was initially offered to them to enroll in an individual plan <ul style="list-style-type: none"> • If the plan selection is prior to the triggering event (the date the person's ICHRA can start), and the triggering event is on the first day of a month, the effective date would be the triggering event date. Otherwise, the effective date would be the first day of the month following the date of the triggering event • If the plan selection is made after the triggering event, the effective date would be first of the month following the plan selection date 	<input type="checkbox"/> ICHRA Form from Employer

GO TO STEP 5

STEP 5 - 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. Yes No

Note: 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.

If your current coverage is through an employer or another insurance carrier, Blue Cross cannot cancel that coverage for you. If you have coverage purchased through MNsure, you must contact MNsure to terminate the coverage.

4. If you answered Yes to one or more questions above, 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: _____

Effective Date of Coverage

During the Open Enrollment Period: January 1, 2022, if the Application is received on or before December 15, 2021.

During the Special Enrollment Period: Your effective date is assigned by Blue Plus based on the eligibility of your selection in Step 4 - Special Enrollment and the completeness of your application.

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

STEP 6 - Notification and Authorization

By completing this enrollment Application, I understand that I will be submitting an actual request for enrollment and I agree to the following:

- My/our signature on this Application indicates that I/we have read and fully understand and agree to the following statements when applying for health coverage through Blue Cross and Blue Shield of Minnesota and 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 and agree that Blue Plus may share my past, current and future health and account records with my network providers about services I've received from my network providers and non-network providers. These records may be used by my network providers as needed to manage or coordinate my care and to improve the quality of that care.

STEP 7 - Payment and Billing Information

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 bill. 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.

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. I understand that these amounts will be subject to premium increases on the date the increase is effective.

STEP 8 - Sign Application

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 or Guardian Signature _____ Date _____

When applying for a policy that covers only a child under the age of 18, the parent or guardian must sign. The parent or guardian signing must be the same person identified on this Application as the contact person.

STEP 9 - 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 982806
El Paso, TX 79998



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 860448
Minneapolis, MN 55486



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 www.bluecrossmn.com/centers/ to make an appointment near you.

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.

For Producer Use Only

PRODUCER ATTESTATION

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, you will not be assigned as the AOR.

Blue Cross Agency Code (10-digit code)

Producer Code (10-digit code)

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

I attest I have reviewed the completed Application with the Applicant(s) and;

- 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 contract. Visit Agent Central and search for "Agent Code of Conduct".
- I am not aware, based on the Applicant's responses to my inquiries, of any factors impacting the eligibility of the Applicant and each of his/her dependents applying for coverage
- 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 any contractual rights or requirements.
- I attest the Applicant was present and signed this Application in my presence.
- I provided a copy of the submitted Application to the Applicant(s), in its entirety, immediately in a secure manner pursuant to all applicable laws
- I agree to retain a copy of the submitted Application for my records and to provide a copy of the submitted Application to Blue Plus upon request.

Agency Name _____

Producer Name _____
FIRST MI LAST

Producer Signature _____ Date _____

Business Telephone _____



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

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

INTERNAL USE ONLY

Blue Cross Agency Code (10-digit code)

Producer Code (10-digit code)

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>.

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.

နမ့်ကတိကညိကျိန်ဒီး, တၢ်ကဟ့ၣ်နၢကျိၣ်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTY
အဂီၢ်, ကိး 711 တက့ၢ်.

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, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃ້ເຈົ້າຟຣີ. 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.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន 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'. Kojí éí béesh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jí' béesh bee hodíílnih.

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