BlueCross BlueShield Minnesota

DELTA DENTAL

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

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone ( )

Employee's Home address	Street	City	State	Zip code	Work phone ( )

Employee's Email address

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

Relation (Circle)	Last name	First name	M.I	Cancel Eff. Date	Add/ Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #
Self					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Spouse					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F	☐ Married ☐ Single			

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

☐ Elect or ☐ Waive Health (self)
☐ Elect or ☐ Waive Health (dependents)
☐ Elect or ☐ Waive Dental (self)
☐ Elect or ☐ Waive Dental (dependents)
☐ Elect or ☐ Waive Supplemental Life (Benefit chosen $_____)
☐ Elect or ☐ Waive STD
☐ Elect or ☐ Waive LTD
☐ Elect or ☐ Waive Life/AD&D (self)
☐ Elect or ☐ Waive Life/AD&D (self with dependent life coverage)

Health plan product name:	Dental plan product name:

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

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

X _____ Month Day Year

Signature of employee Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

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

Monthly salary (Complete only if applying for salary-based benefits) $ _____

Indicate the reason employee is enrolling for coverage:

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

Group numbers:

Health _____ Dental _____ Life _____ STD _____ LTD _____
Department number _____ Class _____

I certify the above information to be true and correct.

Signature _____ Date _____

Employer name	Telephone number ( )	Fax number ( )

E. MEDICARE AND OTHER COVERAGE INFORMATION

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

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

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

If Medicare: check reason for entitlement: ☐ Age ☐ Disability ☐ End-Stage Renal Disease
☐ Disability & Current End-Stage Renal Disease

G. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C

Adding dependents: Date of event

☐ Birth/adoption _____
☐ Court order _____
☐ Marriage _____ County _____
☐ Other _____ Details _____

Cancelling dependents: Date of event

☐ Divorce _____
☐ Other (explain) _____

Loss of prior health and/or dental coverage:
Did you lose health coverage, dental coverage or both? _____

Date of event

☐ Other coverage voluntarily terminated _____
☐ Group continuation (COBRA) period exhausted _____
☐ Employer contribution for coverage terminated _____
☐ Coverage terminated due to loss of eligibility _____ Reason _____

☐ Address change
☐ Primary care clinic change
☐ Phone number change
☐ Name change

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

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