BlueCross BlueShield of Minnesota

City of Eagan

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

Employee's Last Name	First Name	M.I.	Social Security Number	Home Phone ( )
Employee's Home Address	Street	City	State	Zip Code / Work Phone ( )

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

Relation	Last Name	First Name	MI	Birth Date (Mo. Day Yr.)	Add / Cancel	Sex (circle)	Marital Status	Social Security #
Self				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	
Spouse				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	
Child				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	
Child				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	
Child				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	
Child				/ /	☐Add ☐Cancel	M / F	☐Single ☐Married	

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

Health Plan Design

☐ Aware Network - $20 Copay Plan ☐ Aware Network - $1500 Deductible VEBA 1 ☐ Aware Network - $1500 Deductible VEBA 2
☐ Blue Print Network - $1500 Deductible VEBA 1 ☐ Blue Print Network - $1500 Deductible VEBA 2
☐ Waive Coverage (Only employees working less than 30 hours can waive coverage)

Coverage Level:

Health: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

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

X	Month	Date	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:

Indicate the reason employee is enrolling for coverage:

☐ New Employee ☐ Rehire (length of layoff) _____
☐ 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 Number: **CN617**

☐ Active ☐ COBRA ☐ COBRA/Early Retiree (PD 50-55 / Non-PD 0-18 mos under COBRA) ☐ Retiree (PD 55-65 / Non-PD post 18 mos COBRA)

I certify the above information to be true and correct.

Signature _____ Date _____

Employer Name	Telephone number	Fax number

E. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? Yes (complete section below)

Employee:

Effective Date Part A | | | | Effective Date Part B | | | | Medicare Claim Number _ _ _ - _ _ - _ _ _ _ - _

Eligibility reason for Medicare: Age Disability End-Stage Renal Disease Disability & End-Stage Renal Disease

Spouse:

Effective Date Part A | | | | Effective Date Part B | | | | Medicare Claim Number _ _ _ - _ _ - _ _ _ _ - _

Eligibility reason for Medicare: Age Disability End-Stage Renal Disease Disability & End-Stage Renal Disease

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

Adding dependents:	Date of event		Cancelling dependents:	Date of event
Birth/adoption	_____		Divorce	_____
Court order	_____		Other (please explain)	_____
Marriage	_____	County _____		
Other	_____			

Address change _____

Phone number change_____

Name Change_____ Previous _____

List new name in Section A

Loss of prior health coverage

	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 _____

ENROLLMENT CHANGE FORMS SHOULD BE SENT TO:

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