# Application for Individual/Family Plan Health Insurance

BlueCross BlueShield Minnesota

## 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 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: 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 **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 bluecrossmn.com or at 1-800-262-0823 and one of our representatives will be happy to assist you.
- Applicants (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 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 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 the Uniform Glossary are accessible at bluecrossmn.com or available free of charge when requested by calling one 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, health care 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 funds transfer. If you have questions about this third-party payment policy or whether Blue Plus will accept premium and 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?

- 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 plans, 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, use one of these options:
  Online: bluecrossmnonline.com (during Open Enrollment Period only)
  By telephone: 1-800-262-0823

### STEP 1 - Tell us about yourself

☐ Open Enrollment ☒ Special Enrollment

My Blue Cross or Blue Plus ID number: _____

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).
Important: 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, because 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.**

When you include Social Security numbers (SSNs), we can process your Application more efficiently, but you are not required to include them for your dependents or yourself.

| First Name | Last Name and Suffix | | |
|---|---|---|---|
| Social Security Number (If no SSN, write N/A) | Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female | |
| Permanent Home Address (No P.O. Boxes) | | | |
| City | State | ZIP | County |
| Correspondence Address (If different than Home Address) Street | City | State | ZIP |
| Billing Address (If different than Home Address) Street | City | State | ZIP |
| Email 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. I am a permanent resident of Minnesota: ☐ Yes ☐ No I have been a permanent resident of Minnesota since: _____
   **Important:** We can only offer coverage to permanent Minnesota residents. Refer to 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? ☐ Yes/Not sure ☐ No
3. Do you have an Individual Coverage Health Reimbursement Arrangement (ICHRA) through your employer? ☐ Yes ☐ No
4. Do you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) through your employer? ☐ Yes ☐ No
5. For Applicants 21 years of age or older: Have you smoked or used any form of tobacco regularly (Four 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 / Last Name | | | | ☐ Male ☐ Female |
| Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No<br>**If No,** list address: _____ | | | | |
| For dependents 21 years of age or older: Has this dependent smoked or used any form of tobacco regularly (four or more times per week on average excluding religious or ceremonial use), within the last six months? ☐ Yes ☐ No<br>**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 / Last Name | | | | ☐ Male ☐ Female |
| Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No<br>**If No,** list address: _____ | | | | |
| For dependents 21 years of age or older: Has this dependent smoked or used any form of tobacco regularly (four or more times per week on average excluding religious or ceremnial use), within the last six months? ☐ Yes ☐ No<br>**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 / Last Name | | | | ☐ Male ☐ Female |
| Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No<br>**If No,** list address: _____ | | | | |
| For dependents 21 years of age or older: Has this dependent smoked or used any form of tobacco regularly (four or more times per week on average excluding religious or ceremonial use), within the last six months? ☐ Yes ☐ No<br>**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 / Last Name | | | | ☐ Male ☐ Female |
| Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No<br>**If No,** list address: _____ | | | | |
| For dependents 21 years of age or older: Has this dependent smoked or used any form of tobacco regularly (four or more times per week on average excluding religious or ceremonial use), within the last six months? ☐ Yes ☐ No<br>**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 / Last Name | | | | ☐ Male ☐ Female |
| Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No<br>**If No,** list address: _____ | | | | |
| For dependents 21 years of age or older: Has this dependent smoked or used any form of tobacco regularly (four or more times per week on average excluding religious or ceremonial use), within the last six months? ☐ Yes ☐ No<br>**If Yes,** when was the last time this dependent 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. **For assistance, use our Find a Doctor tool:** 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:

**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

Gold
20% Plan
☐ $1,300/$3,900 Plan 254
Silver
30% HSA Plan
☐ $3,000/$9,000 Plan 253
Bronze
0% HSA Plan
☐ $7,500/$15,000 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

Gold
20% Plan
☐ $1,300/$3,900 Plan 272
Silver
30% HSA Plan
☐ $3,000/$9,000 Plan 271
Bronze
0% HSA Plan
☐ $7,500/$15,000 Plan 270

**Blue Plus Minnesota Value** - Single/Family Plans

**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, Mahnomen, 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

**Network** - Blue Plus Minnesota Value

Gold
20% Copay Plan
☐ $1,000/$3,000 Plan 205
20% Plan
☐ $1,300/$3,900 Plan 202
0% HSA Plan
☐ $3,500/$10,500 Plan 207
Silver
30% Copay Plan
☐ $3,000/$9,000 Plan 204
30% HSA Plan
☐ $3,000/$9,000 Plan 201

Bronze
35% Copay Plan
☐ $5,800/$11,600 Plan 203
0% HSA Plan
☐ $7,500/$15,000 Plan 200
40% Plan
☐ $7,500/$15,000 Plan 206

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, changes in your family size (e.g., giving birth to or adopting a child or getting married) 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 in 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 documents, 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, date of change or termination and everyone that will be covered by the plan. See Supporting Documents below for additional required information.

Date of qualifying life event: _____

| Qualifying Life Event | Coverage Effective Date<br>**Note:** The coverage effective date cannot be prior to the occurrence of the event. | Supporting Documents |
|---|---|---|
| ☐ Loss of pregnancy related or medically needy coverage under Medicaid<br>☐ Loss of minimum essential coverage (MEC) (includes but is not limited to)<br>☐ Loss of eligibility for employer-sponsored coverage due to job loss or reduction in hours<br>☐ Employer no longer offers benefits or closes<br>☐ Legal separation/divorce from policyholder<br>☐ Employee/policyholder becomes Medicare-entitled<br>☐ Death of policyholder<br>☐ Child loses dependent status<br>☐ Loss of eligibility for Medicaid, MinnesotaCare or CHIP<br>☐ Expiration of COBRA or non-calendar year policy or loss of employer COBRA contributions<br>☐ 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:<br>• 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<br>• If the plan selection is after the loss of coverage, the effective date is the first day of the month following the plan selection<br><br>**NOTE:** Voluntarily quitting other health coverage and 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 coverage, including:<br>• Termination date<br>• People covered by the plan<br>• Reason for termination<br>☐ Letter of termination from carrier (includes dependent age maximum reached)<br>☐ Notice of termination of government-sponsored coverage<br>☐ Letter/notice of termination of benefits from the employer (includes divorce from policyholder, death of policyholder or policyholder becomes Medicare-entitled)<br>☐ COBRA eligibility notice or documentation showing that COBRA coverage or non-calendar year policy is ending<br>☐ Letter of termination from carrier/ insurance company and proof of address change |
| ☐ A permanent move to a new area that offers different health plan options. You must have had minimum essential coverage (MEC) for one or more days during the 60 days preceding the permanent move, unless you have an eligible exception<br>☐ Release from incarceration<br>☐ Return from active military service | • If the plan selection is between the 1st and 15th of the month, your coverage will start on the first day of the following month<br>• If the plan selection is between the 16th and end of the month, your coverage will start on the first day of the second month | ☐ Proof from prior carrier of MEC<br>☐ Proof of new residence, such as dated rental/lease agreement, deed, purchase agreement, new driver's license or state photo ID card<br>☐ Notice from carrier no longer providing health coverage<br>☐ A utility bill in the Applicant's name and containing the new address<br>☐ Prison release form<br>☐ Supporting paperwork confirming departure date from active military service |
| ☐ Marriage. You or your spouse must have had minimum essential coverage (MEC) for one 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. | ☐ Proof from prior carrier of MEC<br>☐ Marriage certificate |



STEP 4- Continued

| STEP 4 – Special Enrollment - continued | | |
|---|---|---|
| **Qualifying Life Event** | **Coverage Effective Date**<br>**Note:** The coverage effective date cannot be prior to the occurrence of the event. | **Supporting Documents** |
| ☐ Birth<br>☐ Adoption<br>☐ Placed for adoption<br>☐ Placed in foster care<br>☐ Court order | ☐ Date of qualifying life event<br>OR<br>☐ The first day of the month following the plan selection | ☐ Birth certificate<br>☐ Existing Blue Cross or Blue Plus member with proof of claims for birth<br>☐ Legal papers for adoption or foster care<br>☐ Court order |
| ☐ Untimely notice of triggering special enrollment event | Notification can be 60 days from notice of the special enrollment event<br>☐ Earliest date available had the notice been timely<br>OR<br>☐ The first day of the month following the plan selection | ☐ Letter confirming the untimely notice of the special enrollment event |
| ☐ 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. | • If the plan selection is between the 1st and 15th of the month, your coverage will start on the first day of the following month<br>• If the plan selection is between the 16th and end of the month, your coverage will start on the first day of the second month | ☐ Copy of MNsure eligibility notice |
| ☐ MNsure or carrier determined that an unintentional enrollment error is the result of an action or omission by an agent of MNsure or Non-Exchange Entity.<br>☐ MNsure determined 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 or carrier:<br>• You must send in the necessary supporting documentation from MNsure along with this form and a completed Application | ☐ Copy of MNsure or carrier eligibility notice |
| ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) through employer or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) | Notification can be 60 days from the date the ICHRA/QSEHRA was initially offered to the individual for enrollment into an individual plan.<br>• If the plan selection is prior to the triggering event (the first date the person's ICHRA/QSEHRA coverage can take effect), coverage must start the first of the month after the triggering event, or if the triggering event is on the first day of a month, the effective date would be the triggering event date.<br>• If the plan selection is made on or after the triggering event, the effective date would be the first day of the month following the plan selection | ☐ ICHRA/QSEHRA Form from Employer |

*APTC is only available through MNsure



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 Policyholder: _____ Effective Date: _____

Policy Number: _____ Relationship to Applicant: _____

Policyholder's Date of Birth: _____ Policyholder's Employment Status: _____

### Effective Date of Coverage

**During the Open Enrollment Period: January 1, 2023**, if the Application is received on or before December 15, 2022.
**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. If you do not complete the Remittance Slip, you will be billed separately for your first month's premium.

**Notes:** 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 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: _____ 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 or email your Application, mail in this page with your first month's 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 – 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 toward 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 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.
  State and/or Federal ACA compliance obligations may arise if the policy is funded in whole or in part by an employer. By submitting this application and paying the applicable premium, the applicant/payor confirms that it is in compliance with all applicable legal requirements, and that any employer funded policy is offered in compliance with applicable state and federal law such as offering such coverage through an ACA compliant ICHRA or QSEHRA arrangement.
- 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 immediately notify Blue Plus of any changes to information about me or my dependants contained in this Application. 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, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- Upon request, I agree to furnish additional information about me or my dependants concerning eligibility. 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, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- By providing my email address, I agree to receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Plus and its affiliates. I may unsubscribe or change my email address at any time by following the instructions included in each email communication.
- By providing my telephone number, I expressly consent to accept and receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Plus and its affiliates, via text message or voice call to my mobile device and to the cellular/mobile telephone number(s) that I provided.
  - NOTE: Email 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 email or text message from an unsecured email or device, Blue Plus does not accept liability for any errors or omissions in the contents of the email or text message, which arise as a result of email 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.



GO TO STEP 7

## 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 ongoing 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 email:

**Fax your completed, signed Application to (651) 662-6439 or email 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 center:

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

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) |
|---|---|
| 0002581830 | 0002581373 |

**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. Note: 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 that 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 King and Companies

Producer Name Sandra (FIRST) MI Shclaefer (LAST)

Producer Signature Sandra Shclaefer Date _____

Business Telephone (952) 746-5959

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 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.

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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.

နမ့်ကတိၤကသိကျိာ်ဒီး, တ်ကဟ့ာ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, 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, 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 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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