



An independent licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Application and/or Waiver of Coverage for Group Benefit Plans

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)
PO BOX 4309
HELENA MT 59604

Important Notices

Please Read Prior to Completing this Application

Special Enrollment Rights: If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible to enroll yourself and/or your dependents in this plan, provided you request enrollment within 31 days after your other coverage ends due to loss of eligibility or the employer ceases contribution toward that coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Preexisting Condition Exclusion Period: The plan in which you are enrolling may have a preexisting condition exclusion period before preexisting conditions are covered. The preexisting condition exclusion period does not apply to members under 19 years of age. Your employer will give you a notice of any preexisting condition exclusion period when you receive this application. Please do not sign this application until your employer provides you with a notice of the preexisting condition exclusion period.

Applicant/Subscriber Name: _____

APPLICATION AND/OR WAIVER OF COVERAGE FOR GROUP BENEFIT PLANS
PLEASE PRINT IN BLACK INK

Purpose	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Family Member <input type="checkbox"/> Transfer (Current ID Number) <input type="checkbox"/> Waive Coverage	Plan Applying For		IMPORTANT ALL FAMILY MEMBERS MUST BE LISTED. Generally, this is your spouse and legally dependent children or stepchildren as defined in your group's contract. Application is required to add a family member as a result of birth, marriage, adoption, or placement for adoption.
	<input type="checkbox"/> Traditional <input type="checkbox"/> PPO <input type="checkbox"/> Other		<input type="checkbox"/> Managed Care <input type="checkbox"/> Big Sky Select <input type="checkbox"/> Blue Select	

Warning! Waiver of coverage may result in you and/or your dependents being treated as a "late enrollee." Future enrollment may be limited to special enrollment and open enrollment time periods, should they occur. Additionally, you and/or your dependents 19 years of age or older may be subject to a preexisting condition exclusion period.

Applicant/Subscriber	ENROLLING	WAIVING	Last Name	First Name	MI	Social Security Number (SSN) <small>Your SSN may be included in your Subscriber Identification Number.</small>	Date of Birth <small>(mo day yr)</small>	Male/ Female	
	Applicant/Subscriber Mailing Address				City	State	ZIP Code	Home Telephone	
	Email Address								
	Personal Care Physician (PCP) Name and City <small>(required only for Managed Care Plans)</small>					Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married* <small>*Complete spouse's information below.</small>		Date of Marriage <small>(mo day yr)</small>	

Spouse and Dependent(s)	ENROLLING	WAIVING	All family members must be listed. Indicate for each family member whether enrolling or waiving coverage.								
			Last Name	First Name	MI	Social Security Number	Date of Birth <small>(mo day yr)</small>	Male/Female	Relationship	Personal Care Physician Name and City <small>(required only for Blue Select)</small>	

Waiving Coverage	Is the Applicant/Subscriber covered under another health plan or agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	If yes, is the Applicant/Subscriber covered under another health plan or agreement as a dependent spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	If waiving coverage, is it due to coverage under a group health plan or agreement as a dependent spouse/child? <input type="checkbox"/> Yes <input type="checkbox"/> No									
By my signature, I AM WAIVING COVERAGE FOR MYSELF AND ALL FAMILY MEMBERS. (If not waiving coverage, complete the application.) Applicant/Subscriber, sign here <u>only</u> if Waiver of Coverage is for <u>all</u> family members: _____ Date: (mo day yr) _____										
If you have signed above to waive coverage for yourself and all family members, it is not necessary to complete the rest of this form; however, your employer must complete the employer section on page 11 prior to submitting the form to BCBSMT.										

BCBSMT OFFICE USE ONLY	Group Number			Small Group <input type="checkbox"/> Yes <input type="checkbox"/> No		BCBSMT Date Stamps				
	CT	Package	Dept.							
	Probationary Period		Effective Date							
	Underwriter Initials			BC:	Mailed:					

Applicant/Subscriber Name:

This section must be completed for all Applicants/Subscribers.

Creditable Coverage:

- ◆ Including, but not limited to Medicare, Medicaid, employer-based insurance, or health insurance coverage.
- ◆ Does not include limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy.

Creditable Coverage: If you or your dependents, 19 years of age and older, had health coverage within the last 63 days or within 63 days of the date on which a certificate of creditable coverage was issued (not including days required to satisfy the employer's probationary waiting period before the member is eligible to apply), the preexisting condition exclusion period will be reduced by the combination of the periods of Creditable Coverage that the member had as of the enrollment date of this plan. In addition, please attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents. The previous health insurance carrier must provide a certificate of Creditable Coverage with the end date of that coverage. BCBSMT will assist you or your dependents, if necessary, in obtaining this certificate or the necessary information from previous health insurance carriers.

Have you or your dependents had health coverage within the last 63 days? Yes No
 If yes, attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents.

Loss of Eligibility for Other Coverage: If you are enrolling because you lost eligibility for other health coverage or the employer ceased the employer's contribution toward that coverage, please indicate below for each person applying due to a loss of eligibility. Application for enrollment based on loss of eligibility must be received by BCBSMT within 31 days of the date the eligibility for the other health coverage ends.

Please fill out the following to verify Creditable Coverage or loss of eligibility if applicable.

Warning: Omissions or incomplete answers may cause delay

Name of Person Covered (include last name if different from Applicant/Subscriber)	Self: ID #*:	Spouse: ID #*:	Dependent: ID #*:	Dependent: ID #*:
Loss of Eligibility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name of Insurance Company or Carrier				
Check Type of Coverage	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
	(mo day yr)	(mo day yr)	(mo day yr)	(mo day yr)
Date of Enrollment				
Date of Cancellation				
Will this coverage be continued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*ID # is your identification number under previous or current insurance company or carrier.

This section is required for employees enrolling themselves and/or their dependents on a small employer† group plan.

†Ask your employer whether you need to complete the Medical History section.

Please do not provide any information regarding any genetic tests you or any family member have had, the results of such tests, or any family medical history (other than medical history requested in this application) that may indicate genetic predisposition to any disease or disorder.

If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.

A. List current height and weight for all persons to be covered age 6 months and older.

Name of Person	Current Height	Current Weight	Name of Person	Current Height	Current Weight

B. Within the last three (3) years, have medications (except antibiotics) been prescribed for, been provided for (e.g., samples, injections), and/or been taken by any person to be covered? Yes No **If yes, please explain below.**

Name of Person	Name of Medication	Daily Dosage	Condition for Which Medication Was Prescribed or Taken	Dates	
				From (mo day yr)	To (mo day yr)

PLEASE PRINT IN BLACK INK

To Be Completed by the Employer	Name of Group or Firm:		Group Number:		
	Name of Employee:		Occupation:		
	Current Number of Hours per Week	Date employee started working the required number of hours to become eligible for coverage. (This is the date BCBSMT will begin to calculate the probationary period for health care coverage.)			(mo day yr)
	Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Signature of Group Leader or Authorized Signer		Signature Date (mo day yr)	Please Print Name of Group Leader or Authorized Signer	
	Informational for Employee/Employer payroll deduction purposes only. EMPLOYER: Please refer to employee. Check Type of Coverage Applying for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Spouse/Child <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Spouse/Children				

The sections below must be completed by Applicant/Subscriber.

Conditions of Enrollment	<p>I/We certify and understand the following:</p> <ol style="list-style-type: none"> I/We personally completed the Medical History section (if required) of this form, providing all requested information. All of the statements and responses in this application are complete, accurate, and current for the Applicant/Subscriber, and for the spouse and all dependents for whom coverage is requested This is an application only. No right is conferred to me or any person listed on this application until Blue Cross and Blue Shield of Montana enrolls me/us and dues (premiums) are paid. I/We understand that preexisting condition exclusion periods may apply although preexisting condition exclusion periods do not apply to members under 19 years of age. I/We, the undersigned, am/are applying for membership with Blue Cross and Blue Shield of Montana. I/We agree to the terms and conditions of any certificate issued to me/us by Blue Cross and Blue Shield of Montana. I/We understand that Blue Cross and Blue Shield of Montana maintains contracts with certain providers of medical services. I/We understand Blue Cross and Blue Shield of Montana will pay those providers and any other provider it chooses directly. I authorize my employer to pay dues (premiums) at the prevailing rates required by this application for membership with Blue Cross and Blue Shield of Montana. I understand that I may be required to pay a portion of the dues (premiums). 																
Conditions of Enrollment for Managed Care — Applicant/Subscriber Only	<p>This section applies to all Managed Care Plans.</p> <ol style="list-style-type: none"> For Managed Care Applicant/Subscriber: I/We have reviewed the Managed Care literature. I/We understand that this form of health care coverage is based on a partnership between me/us and my/our Personal Care Physician (PCP). I/We have reviewed and I/we understand the policies relating to urgent and emergency care, payment of services, and copayments. For Managed Care Applicant/Subscriber Living or Working Within 30 Miles of a Managed Care Network of PCPs: I/We acknowledge that Blue Cross and Blue Shield of Montana has a Managed Care Network of PCPs within 30 miles of my/our place(s) of residence or work. However, I/we have voluntarily chosen a Managed Care PCP located farther than 30 miles from my/our place(s) of residence or work. Please initial below: _____ Applicant/Subscriber _____ Spouse _____ Dependent 18 and over _____ Dependent 18 and over _____ Dependent 18 and over 																
Signature(s)	<p>I/We understand and agree that the coverage I/we am/are applying for is subject to the employer's eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I/We have read the Conditions of Enrollment. I/We understand and agree to them.</p> <p style="text-align: center;"><i>Must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying.</i></p> <table border="1"> <thead> <tr> <th>Signature(s) DO NOT PRINT</th> <th>Signature Date (mo day yr)</th> <th>Signature(s) DO NOT PRINT</th> <th>Signature Date (mo day yr)</th> </tr> </thead> <tbody> <tr> <td>Applicant/Subscriber</td> <td></td> <td>Spouse</td> <td></td> </tr> <tr> <td>Dependent</td> <td></td> <td>Dependent</td> <td></td> </tr> <tr> <td>Dependent</td> <td></td> <td>Dependent</td> <td></td> </tr> </tbody> </table>	Signature(s) DO NOT PRINT	Signature Date (mo day yr)	Signature(s) DO NOT PRINT	Signature Date (mo day yr)	Applicant/Subscriber		Spouse		Dependent		Dependent		Dependent		Dependent	
Signature(s) DO NOT PRINT	Signature Date (mo day yr)	Signature(s) DO NOT PRINT	Signature Date (mo day yr)														
Applicant/Subscriber		Spouse															
Dependent		Dependent															
Dependent		Dependent															