

NAME (LAST)	(FIRST)	(MI)	Social Security Number
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E. PERSONAL DATA

List below spouse and other dependent(s) to be covered including eligible children under age 26. LIST IN ORDER OF AGE - OLDEST FIRST.

Full Name (Last, First, MI)	Social Security Number	Date of Birth (Mo./Day/Yr.)	M	F	Relation to Employee
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

F. CURRENT INSURANCE INFORMATION - Complete this section if you are keeping other insurance in addition to this plan.

Insurance Company	Insured's Name	Names of Covered Persons	Effective Date	Address and Telephone of Insurance Company

MEDICARE SECONDARY PAYOR INFORMATION

Are you, your spouse, or your dependent(s) enrolled in Medicare? Yes No If the answer is "yes," please fill in requested information below:

If Medicare: Name of Beneficiary _____

Medicare HIC #: _____ Part A effective date: _____ Part B effective date: _____

Reason for entitlement (check all applicable boxes): Age Disability End stage renal disease

G. I represent that my answers and statements in this enrollment form are true and complete to the best of my knowledge and belief. I understand that any intentional misrepresentation in this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by this application. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims.

By providing your telephone numbers you agree that we, along with our affiliates and/or vendors, may call or test any phone numbers you give us, including a wireless number, using an automatic telephone dialing system and/or a prerecorded message. Without limit, these calls may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

SPECIAL ENROLLMENT NOTICE

If you decline enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 31 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). This Special Enrollment provision is subject to EHA eligibility guidelines for the Direct Bill plan.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Signature of Applicant: _____ **Date:** _____

Additionally, if you decline coverage and your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information contact our Member Services department at 877-721-2583.

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 771 between 8 a.m. to 9 p.m., Central time, seven days a week from Oct. 1 through March 31; 8 a.m. to 9 p.m., Central time, Monday through Friday from April 1 through Sept. 30.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance is available to help you.

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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدكم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840.

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

