BlueCross BlueShield Nebraska

PO Box 3248 • Omaha, Nebraska 68180-0001

# BlueFreedom Employee Enrollment Form

| For Internal Use |
|---|
| Account No. |
| SubAccount No. |

☐ New Group ☐ New Hire ☐ Change

**Please print** and **complete all sections** of this enrollment form with black ballpoint pen. Be sure to complete all questions in full. Incomplete enrollment forms cause unnecessary delays. If you need more space for any answers, you can use a separate piece of paper. Please include your name and Social Security Number. **If declining coverage, please complete section H.**

## Section A. Applicant Information

| Social Security Number | Name (Last) (First) (MI) (Title) | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female |
|---|---|---|---|
| | | | |

Address (Street, PO Box) (City) (State) (ZIP+4 Code) (County)

| Home Phone Number | Work Phone Number | Cell Phone Number | Email Address | Marital Status: ☐ Single ☐ Married ☐ Divorced |
|---|---|---|---|---|
| | | | | |

| Account/Group Name (Employer or Organization) | Account/Group Number | SubAccount Number |
|---|---|---|
| | | |

| Job Title | Date Employed with Group | Hours Worked per Week | Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? If Yes, please give name(s) & ID number(s). ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

Are you or your spouse terminating other Blue Cross and Blue Shield coverage? If Yes, please complete Section E. Loss of Coverage ☐ Yes ☐ No

Are you a member of a federally-recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

## Section B. Health and Dental Election(s) for Newly Eligible Employees

**Choose your health and dental option(s):**

**☐ HEALTH**
- ☐ Employee only
- ☐ Employee and spouse
- ☐ Employee and child(ren)
- ☐ Family

**☐ DENTAL**
- ☐ Employee only
- ☐ Employee and spouse
- ☐ Employee and child(ren)
- ☐ Family

**If Dual Option Group:**
Please indicate deductible chosen:
$ _____

(If applicable to your plan)
**HEALTH NETWORK OPTION** (not all options may be available to you under your Plan)
- ☐ NEtwork BLUE
- ☐ Premier Select BlueChoice
- ☐ Blueprint Health
- ☐ Other - network name: _____

Within the past six months, have you or any dependents used tobacco products four or more times in a week? ☐ Yes ☐ No

## Section C. Coverage Change Election(s) For Current Members

**Indicate your coverage changes:** ☐ **Health only** ☐ **Dental only** ☐ **Both**

☐ Change To: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family

**Change reason:** ☐ Marriage ☐ Divorce ☐ Childbirth ☐ Other: _____ Date: _____

☐ Add new dependent(s): _____ Date dependent(s) joined your household: _____ (Complete Section D.)

_____ Date dependent(s) joined your household: _____ (Complete Section D.)

_____ Date dependent(s) joined your household: _____ (Complete Section D.)

☐ Change network options (if applicable) ☐ NEtwork BLUE ☐ Premier Select BlueChoice ☐ Blueprint Health
☐ Other - network name: _____

☐ Other health changes: _____

Within the past six months, have you or any dependents used tobacco products four or more times in a week? ☐ Yes ☐ No

| Name (Last) (First) (MI) (Title) | Social Security Number |
|---|---|
| | |

## Section D. Personal Data

List below spouse and other dependent(s) to be covered including eligible dependent children under age 26. List in order of age - oldest first.

| Full Name (Last, First, MI) | Height | Weight | Social Security Number | Date of Birth (MMDDYYYY) | M | F | Relation to Employee |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | |
| | | | | | ☐ | ☐ | |

## Section E. Loss of Coverage - Special Enrollment

Are you or your dependent terminating (or losing) other health coverage? ☐ Yes ☐ No

If Yes, please complete the following:

1) Give us the reason for loss of other health coverage:

☐ Employment terminated ☐ Death, divorce or legal separation ☐ I/we voluntarily chose to drop other insurance

☐ Spouse employment terminated ☐ I/we have reached the end of COBRA coverage ☐ Other: _____

2) Coverage termination date: _____

3) Please provide the notice of termination, or loss of eligibility documentation from the other insurance company.

## Section F. Medicare Secondary Payor Information

Are you, your spouse, or your dependent(s) enrolled in Medicare? ☐ Yes ☐ No If the answer is "Yes," please complete the 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

| Name (Last) (First) (MI) (Title) | Social Security Number |
|---|---|
| | |

## Section G. Health History

Answer each question YES or NO. For conditions answered "Yes," give details below.

**This information is necessary for rating purposes. Your enrollment for health coverage will not be declined based on answers to these questions, or any health status-related factors. You should not disclose genetic information (including family history). If you are a new hire or changing your coverage, you are not required to complete this section. To request a copy of our Privacy Policy, contact us toll free at 800-642-8980 or visit NebraskaBlue.com/Privacy.**

1. In the past 5 years, have you or any of your dependents been tested, diagnosed or treated (including prescription medication usage) or been advised to seek treatment for:
   1. Alcohol or drug abuse..... ☐ Yes ☐ No
   2. Arthritis, bone, joint, spine, muscle or connective tissue disorder..... ☐ Yes ☐ No
   3. Autoimmune disease, including Crohn's disease, Lupus or Multiple Sclerosis..... ☐ Yes ☐ No
   4. Cancers, tumors or polyps..... ☐ Yes ☐ No
   5. Circulatory, blood or heart disorders including high blood pressure..... ☐ Yes ☐ No
   6. Cirrhosis, hepatitis or any other disease of the liver..... ☐ Yes ☐ No
   7. Cystic Fibrosis or Rheumatic Fever..... ☐ Yes ☐ No
   8. Digestive disorders including any conditions of the colon, esophagus, gallbladder, intestines, pancreas or stomach.... ☐ Yes ☐ No
   9. Diabetes, hyperthyroidism, hypothyroidism or any endocrine disorder or disease..... ☐ Yes ☐ No
   10. Manifested genetic or developmental disorders including use of growth hormones..... ☐ Yes ☐ No
   11. HIV/AIDS or any other immune system disorder..... ☐ Yes ☐ No
   12. Infertility or any other reproductive system disorder..... ☐ Yes ☐ No
   13. Lung disease or disorder..... ☐ Yes ☐ No
   14. Neurological disorders including Alzheimer's, cerebral palsy, epilepsy, migraines, Parkinson's or seizures..... ☐ Yes ☐ No
   15. Organ transplant..... ☐ Yes ☐ No
   16. Paralysis including paraplegia and quadriplegia..... ☐ Yes ☐ No
   17. Vascular disorders including stroke, CVA or TIA..... ☐ Yes ☐ No
2. In the past 5 years, have you or any of your dependents been hospitalized, had surgery or plan to have surgery for any illness, injury or condition or is anyone currently pregnant?..... ☐ Yes ☐ No
3. In the past year, have you or any of your dependents incurred medical or pharmacy expenses in excess of $5,000?..... ☐ Yes ☐ No

**For any "Yes" answers identified above, please provide complete details below. Attach a separate piece of paper if necessary.**

| Question Number | Person | Condition | Treatment Performed or Recommended | Degree of Recovery |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Section H. Declination of Coverage

**Complete only if you elect not to participate in the group insurance offered.**

**The group health/dental program has been offered to me and I choose:**

☐ not to enroll myself or my dependents in the health plan.

☐ not to enroll myself or my dependents in the dental plan.

**Coverage in the health/dental plan is declined because:**

☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's health coverage.
My spouse is employed by (name of firm) _____

☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's dental coverage.

☐ I am enrolled and/or ☐ My dependents are enrolled, under a COBRA continuation coverage or state continuation coverage.

☐ I have and/or ☐ My dependents have, individual coverage through ☐ Medicare ☐ Medicaid ☐ SCHIP ☐ another insurance company

☐ Other reason(s) _____

| Name (Last) | (First) | (MI) | (Title) | Social Security Number |
|---|---|---|---|---|
| | | | | |

## Section I. Acknowledgement and Authorizations

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 it. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

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

If you wish to opt out of electronic/automatic telephonic messages, please contact Member services department at 402-390-1820 or 888-592-8961.

**Special Enrollment Notice**
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 yourself and 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 yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or 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.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or 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 402-390-1820 or 844-201-0763.

Signature of Applicant: _____ Date: _____