BlueCross BlueShield Nebraska

Educators Health Alliance Medical and Dental Enrollment Form

☐ New Application (Complete all sections except Section D. Complete Section B, if applicable)

☐ Change (Complete all sections except Section C. Complete Section B, if applicable.)

Please print in black ink. If you need more space you can use a separate sheet of paper. Please include your name and social security number.

Section A. Applicant Information

Social Security Number	Name (Last) (First) (MI)	Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F

Address (Street, PO Box) (City) (State) (ZIP Code)	Telephone Number	☐ Single ☐ Married ☐ Divorced

Email

School District Name	Classification (to be completed by employer)	Account No./ Group No.	Sub Account/ Roll No.	Job Title	Date Employed w/ Group	Hours worked per week

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield members or applicants? ☐ Yes ☐ No

If yes, please include name(s) and ID number(s).

Is your spouse terminating other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No

If Yes, please include reason and effective date:

Section B. 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 have decided:

- ☐ Not to enroll myself in the medical/dental plan
- ☐ Not to enroll myself and my dependents in the medical/dental plan
- ☐ Not to enroll my dependents in the medical/dental plan

Coverage in the medical/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 a COBRA continuation or state continuation coverage.
- ☐ I have and/or my dependents have, individual coverage through: ☐ Medicare ☐ Medicaid ☐ SCHIP ☐ Another insurance company
- ☐ Other reason(s) (please specify) _____

If you decline medical/dental plan enrollment for yourself and your dependents, a request for enrollment at a later date may not be allowed, or may be subject to late enrollment restrictions (if requested outside a Special Enrollment Period). See "Special Enrollment Notice" above.

Signature of Applicant: _____ Date: _____

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Name (Last)	(First)	(MI)	Social Security Number

Section C. Medical and Dental Election(s) for Newly Eligible Employees

☐ Medical

HEALTH NETWORK OPTION: Not all options may be available to you under your plan

☐ Dental

☐ One Person
☐ Employee/Spouse
☐ Employee/Children
☐ Family

☐ Standard Copay Option
☐ $2,500 Deductible Option (if available for your school district)
☐ HSA-eligible High Deductible Plan Option (if available for your school district)

Select Network Option: (If applicable to your plan)
☐ NEtwork BLUE
☐ Blueprint Heath
☐ Premier Select BlueChoice

☐ Employee Only
☐ Employee/Spouse
☐ Employee/Children
☐ Family

Section D. Health and Dental Change Election(s) for Current Members (Complete Section D also to add Dependents)

Change to:
☐ Employee Only Medical
☐ Employee/Spouse Medical
☐ Employee/Children Medical
☐ Family Medical

Change to:
☐ Employee Only Dental
☐ Employee/Spouse Dental
☐ Employee/Children Dental
☐ Family Dental

Change to: (If applicable to your plan)
☐ NEtwork BLUE
☐ Blueprint Health
☐ Premier Select BlueChoice

Change Reason: ☐ Divorce ☐ Spouse Deceased ☐ Marriage ☐ Other Date: _____

☐ Add Dependent(s): Date Dependent(s) joined your household: _____

☐ Other Health/Dental Changes: _____

Section 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 (Month, Day, Year)	Sex M	Sex F	Relation to Employee
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Section F. Prior Insurance Information

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
☐ Spouse employment terminated
☐ Death, divorce, or legal separation
☐ Reached the end of COBRA coverage
☐ Voluntarily chose to drop other insurance
☐ Other: _____

2) Coverage termination date: _____

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

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Name (Last)	(First)	(MI)	Social Security Number

Section G. Current Insurance Information - Complete this section if you or a dependent has other insurance in addition to this Plan.

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

Medicare Secondary Payor Information

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

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

Section H. Acknowledgment and Authorization

I represent that my answers and statements in this enrollment form are true and complete to the best of my knowledge. 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 (BCBSNE) reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize BCBSNE 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 BCBSNE along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless number, using an automated phone system and/ or a prerecorded message. 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/telephonic messages, please contact our Member Services department at 877-721-2583.

Special Enrollment Notice:
If you decline 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 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 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: 877-721-2583.

Signature of Applicant: _____ Date: _____

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