BlueCross BlueShield of Nebraska

P.O. Box 3248 • Omaha, Nebraska 68180-0001

An Independent Licensee of the Blue Cross and Blue Shield Association.

BlueFreedom Health Enrollment Form

FOR INTERNAL USE

Group Number _____

Group Department _____

☐ 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. **Complete Section B, if applicable.**

A. APPLICANT INFORMATION

Social Security Number	Name (Last) (First) (M.I.) (Title)	☐ Male ☐ Female

Date of Birth (mmddyy)	Height ′ ″	Weight lbs	Home Phone Number ( )	Work Phone Number ( )	Cell Phone Number	Marital Status: ☐ Single ☐ Married ☐ Divorced

Address (Street, P.O. Box, Apt. #) (City) (State) (Zip+4 Code) (County)

Group Name (Employer or Organization)	Date employed with Group (mmddyy)	No. of hours worked per week

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? ☐ Yes ☐ No If Yes, please give name(s) & ID number(s).

Are you, your spouse or your dependent(s) terminating other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No If Yes, please give reason and date (mmddyy):

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 after seriously considering its benefits, I have decided:

☐ not to enroll myself in the health/dental plan.
☐ not to enroll myself and my dependents in the health/dental plan.
☐ not to enroll my dependents in the health/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 a COBRA continuation or state continuation coverage.
☐ I have and/or ☐ My dependents have, individual coverage through ☐ Medicare ☐ Medicaid ☐ another insurance company
☐ Other reason(s) _____

Signature of Applicant: _____ Date: _____

C. HEALTH AND DENTAL ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES

I HEREBY APPLY FOR:

☐ HEALTH
☐ One Person
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)

If Dual Option Group
Please indicate deductible
$ _____

If High Deductible Health Plan, Select One
☐ Health Savings Account (HSA) (Please complete form 37-044, if applicable)
☐ No Account Set-Up Required

☐ DENTAL
☐ One Person
☐ Family
☐ Employee and Spouse
☐ Employee and Child(ren)

☐ MEDICARE SUPPLEMENTAL
(Not available to active employees or their spouses age 65 and older unless the group has fewer than 20 full and/or part-time employees.)

D. PERSONAL DATA

List below spouse and other dependent(s) to be covered including unmarried dependent children under age 19 and any full time student dependents. **List in order of age - oldest first.**

Full Name (Last, First, M.I.)	Social Security Number	Date of Birth (mmddyy)	Height ′ ″	Weight lbs	(X) Sex M	F	Relation to Employee	Name of School (If Dependent is Age 19 or over)	Credit Hours per Semester

Applicant's Name (Last)	(First)	(M.I.)	(Title)	Social Security Number

E. COVERAGE CHANGE ELECTION(S) FOR CURRENT MEMBERS

I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE: ☐ **Health Only** ☐ **Dental Only** ☐ **Both**

☐ Change to One Person Coverage ☐ Change to Employee and Child(ren) Coverage; Reason: ( ) Divorce ( ) Spouse Deceased ( ) Other Change Date_____

☐ Change to Family Coverage ☐ Change to Employee and Spouse Coverage: Date of Marriage _____

☐ Add New Dependent(s): Date Dependent(s) joined your household _____ (Complete Section D.)

☐ Other Health Changes:_____

F. HEALTH HISTORY - Please answer each question Yes or No and explain any Yes answers below. This information is necessary for rating purposes. Your enrollment for health coverage will not be declined based on your answers to these questions, or any health status-related factors. If you are a new hire or are changing your coverage, you are not required to complete this section.

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. Cancer, 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. 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 reproduction 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

Question Number	Person	Condition	Treatment Performed or Recommended	Degree of Recovery

Applicant's Name (Last)	(First)	(M.I.)	(Title)	Social Security Number

G. I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on 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. The Preadmission Certification Program has been explained to me. I understand that all hospitalizations must be precertified by Blue Cross and Blue Shield of Nebraska, or benefits will be reduced. 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.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS NOTICE

This Plan imposes a waiting period for pre-existing conditions. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in an eligibility waiting period for coverage, the six-month waiting period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the waiting period for pre-existing conditions and creditable coverage should be directed to our Customer Service Center at (402) 390-1820 or toll-free 1-800-642-8980.

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 30 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 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information contact our Customer Service Center at (402) 390-1820 or toll-free 1-800-642-8980.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Description and Purpose of Authorization – I authorize any health care provider, pharmacy and pharmacy related service organizations, to release my protected health information (PHI) to Blue Cross and Blue Shield of Nebraska (BCBSNE) for the purpose of determining enrollment, eligibility for benefits, underwriting and any other activities related to the creation, renewal or replacement of a contract for health insurance or health benefits.

I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcriber hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. I understand that my PHI may include information relating to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug abuse).

Terms and Conditions of Authorization – I understand that signing this authorization **is** a condition of my enrollment in BCBSNE's health plan and for my eligibility for benefits. If I decide not to sign this authorization, BCBSNE may decline to enroll me in the health plan or to provide the benefits, or BCBSNE may disenroll me from the health plan.

I understand I may revoke this authorization in writing at any time. Revocation of this authorization will not affect any action taken by BCBSNE in reliance on this authorization. If I revoke this authorization before BCBSNE has received and used the PHI described above, BCBSNE may decline to enroll me in the health plan. Unless revoked earlier, this authorization will expire upon an offer of coverage from BCBSNE.

I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be protected by federal regulations governing the privacy of health information.

Signature of Applicant: _____ Date: _____

If you have a certificate of creditable coverage, please attach it to this enrollment form. If you do not, please send a copy to the following address as soon as you've received it: Blue Cross Blue Shield of Nebraska, P.O. Box 3248, Omaha, NE 68180-0001. Failure to provide this documentation may affect your waiting periods and/or claim payments.