



A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone ()
Employee's Home address	Street	City	State	Zip code	Work phone ()
Employee's Email address					

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (Circle)	Last name	First name	M.I.	Cancel Eff. Date	Add/Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #
Self					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Spouse					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			
Child Stepchild					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	M / F	<input type="checkbox"/> Married <input type="checkbox"/> Single			

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

- Elect or Waive Health (self)
 Elect or Waive Health (dependents)

Health plan product name:

Beneficiary	Full Name	Date of Birth	Relationship
Primary			
Contingent			

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X	Month	Day	Year
	Signature of employee		
			Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:
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Monthly salary (Complete only if applying for salary-based benefits) \$ _____

Indicate the reason employee is enrolling for coverage:

- New employee Rehire (length of layoff) _____ New group
 Return from leave of absence (length of absence) _____
 Previously waived coverage Change from part-time to full-time
 Certificate of coverage termination Other _____

Date of event: _____

Group numbers:

Health _____ Dental _____ Life _____ STD _____ LTD _____
 Department number _____ Class _____

I certify the above information to be true and correct.

Signature _____ Date _____

Employer name	Telephone number ()	Fax number ()
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E. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage?

Yes No

If yes, you must complete the following: (Medicare: List both Part A and B effective dates)

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (Single or Family)	Effective date

If Medicare: check reason for entitlement: Age Disability End-Stage Renal Disease
 Disability & Current End-Stage Renal Disease

G. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C

Adding dependents:	Date of event	Cancelling dependents:	Date of event
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (explain)	_____
<input type="checkbox"/> Marriage	_____	County _____	
<input type="checkbox"/> Other	_____	Details _____	

Loss of prior health and/or dental coverage: Address change

Did you lose health coverage, dental coverage or both? _____ Primary care clinic change

Date of event _____ Phone number change

Other coverage voluntarily terminated _____ Name change

Group continuation (COBRA) period exhausted _____

Employer contribution for coverage terminated _____

Coverage terminated due to loss of eligibility _____ Reason _____

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 64024
St. Paul, Minnesota
55164-0024

Delta Dental of Minnesota is an independent company that does not provide Blue Cross and Blue Shield products and is solely responsible for their dental products. Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.