Health Benefit Plan

Affiliation and Out-of-Area Waiver Form

(Please type or print in black ink)

Return completed forms by:

- Mail: Blue Cross Blue Shield of North Dakota
  Attn: Enrollment Department
  4510 13th Avenue S.
  Fargo, ND 58121

Section 1 - Affiliation

Please indicate the Network name you have chosen for you and your Eligible Dependents.

Network Name	Health Group Number

Section 2 - Out-of-Area Waiver

Eligible Dependent children of the Subscriber or of the Subscriber's living, covered spouse are eligible for this waiver if:

☐ They reside at a facility for children with disabilities or other special needs (Anne Carlsen School, etc.);

☐ They reside outside the Network Service Area.

I certify my Eligible Dependent children listed below meet at least one of the above requirements. I understand all Covered Services received will be reimbursed at the In-Network benefit level.

Child's Name	Address	Date of Birth (MM/DD/YYYY)	Resides at a special needs facility	Dependent child residing Out-of-Area
			☐	☐
			☐	☐
			☐	☐
			☐	☐

I understand my Eligible Dependents and I must receive care within the Network I have selected, with the exception of Eligible Dependent children listed in **Section 2 - Out-of-Area Waiver**. Use of providers outside my Network will result in a reduction of benefits, unless an Authorized Referral has been obtained or the Out-of-Area Waiver is in effect.

Employer/Employee Information

Requested Effective Date	Employer Name
Employee Name (Last, First, M.I.)	Unique Member Identifier
Employee Work Phone Number	Home Phone Number
Employee's Signature	Date