# Application for Individual Plan Health Insurance

**Complete this application in its entirety in blue or black ink. Do not use a pencil or a highlighter.**



Eff. 11/1/2024
Filed 8/29/2024
BND-22-0059565 IND FI
8-24

## STEP 1: APPLICANT'S INFORMATION

**Please note: Processing of your application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.**

First Name* | MI | Last Name* | Gender* ☐ Male ☐ Female

Social Security Number* | Date of Birth (Month/Day/Year)* _____ | Requested Effective Date* _____

Residential Street Address (*Cannot be a P.O. Box*)* | Apt. or Suite Number

City* | County* | State* | ZIP*

Mailing Address *(If different from above)* | Apt. or Suite Number

City | State | ZIP

Home Phone | Work Phone | Mobile Phone

Email Address *(If applicable)*

Tobacco Use?* ☐ Yes ☐ No

Which of the following best describes you?

☐ White or Caucasian ☐ Black or African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) ☐ Middle Eastern or North African ☐ Indian or Pakistani
☐ Northern Asian or Eastern European ☐ Other _____ ☐ Prefer not to answer

What is your ethnicity or ethnic background?

☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Other _____ ☐ Prefer not to answer

What is your preferred language?

☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

*Question is required and must be completed or your application will be delayed.

## STEP 2: CHOOSE YOUR PLAN

**Review the product information to learn what each plan covers. The plan and deductible option you choose will apply to everyone covered by your plan.**

**Benefit Plans:**

☐ **BluePrime Gold Copay (10523796)**
- ($25 Primary Care Visit, $5 Value Based Drug List)

☐ **BlueDirect Gold HSA Eligible (10353824)**
- ($2600 Deductible, 90% Coinsurance, $5 Preventive Drug List)

☐ **BlueDirect Silver HSA Eligible (10353825)**
- ($3500 Deductible, 80% Coinsurance, $5 Preventive Drug List)

☐ **BlueDirect Silver LP HSA Eligible (10430436)**
- ($3300 Deductible, 80% Coinsurance, $5 Preventive Drug List)

☐ **BlueDirect Bronze HSA Eligible (10353826)**
- ($7500 Deductible, 100% Coinsurance, $5 Preventive Drug List)

☐ **BlueCare Gold Copay (10353828, 10867112)**
- ($25 Primary Care Visit, $5 Value Based Drug List)

☐ **BlueCare Silver Copay (10353829)**
- ($45 Primary Care Visit, $5 Value Based Drug List)

☐ **BlueCare Silver LP Copay (10430437)**
- ($45 Primary Care Visit, $5 Value Based Drug List)

☐ **BlueEssential Catastrophic (10353830)**
- ($9,200 Deductible, 100% Coinsurance)

☐ **BlueValue Gold Copay (10743570)**
- ($30 Primary Care Visit, Standardized plan)

☐ **BlueValue Silver Copay (10745086)**
- ($40 Primary Care Visit, Standardized plan)

☐ **BlueValue Bronze Copay (10745087)**
- ($50 Primary Care Visit, Standardized plan)

☐ **DakotaBlue | Altru Gold Copay (10754873)**
- ($5 Primary Care Visit, $5 Value Based Drug List)

☐ **DakotaBlue | Altru Silver Copay (10754874)**
- ($20 Primary Care Visit, $5 Value Based Drug List)

☐ **DakotaBlue | Altru Silver LP Copay (10754872)**
- ($20 Primary Care Visit, $5 Value Based Drug List)

☐ **DakotaBlue | Trinity Gold Copay (10823098)**
- ($5 Primary Care Visit, $5 Value Based Drug List)

☐ **DakotaBlue | Trinity Silver Copay (10823097)**
- ($20 Primary Care Visit, $5 Value Based Drug List)

☐ **DakotaBlue | Trinity Silver LP Copay (10823096)**
- ($20 Primary Care Visit, $5 Value Based Drug List)

## STEP 2: CHOOSE YOUR PLAN

☐ Yes ☐ No Will any portion of the premium be paid by your employer or your spouse's employer, either directly or through wage adjustments or other means of reimbursement?

☐ Yes ☐ No Do you have an Individual Coverage Health Reimbursement Arrangement (ICHRA) through your employer? If yes, please provide a copy of the notice you received from your employer with this application.

Employer Name _____

☐ Yes ☐ No Do you, your employer or any of your Eligible Dependents intend to treat this health benefit plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code? (See back page "Coverage Information" for additional explanation.)

☐ Yes ☐ No Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B?

## STEP 3: REASON FOR APPLYING

☐ **New coverage** (I do not have BCBSND coverage now) ☐ Change in existing BCBSND coverage Coverage End Date _____

**Loss of previous health coverage due to:**

- ☐ Legal Separation/Divorce
- ☐ Death
- ☐ Termination of Employment/Reduction of Hours
- ☐ Employer Contribution Terminated
- ☐ Loss of COBRA (Benefits Exhausted)
- ☐ Loss of Medicaid
- ☐ Spouse Move to Medicare
- ☐ Other _____

Termination letter from previous carrier identifying the reason for loss of coverage is required.

| **Life event:** | **Supporting documentation required:** |
|---|---|
| ☐ Annual Enrollment | Only applicable during Open Enrollment season |
| ☐ Marriage | Marriage certificate |
| ☐ Birth | Birth certificate |
| ☐ Adoption | Adoption papers |
| ☐ Legal Guardianship | Legal guardianship papers |
| ☐ Permanent Move | Termination explanation from previous carrier |
| ☐ Turning 26 (Aging Off Plan) | Termination explanation from previous carrier |
| ☐ Court Order | Court Papers |
| ☐ ICHRA | Notice received from your employer |

## STEP 4: SPOUSE/DEPENDENT(S) TO BE INSURED INFORMATION *(Use extra paper if necessary)*

**If a spouse and/or dependent should be included on your plan, complete the fields marked with an asterisk (*) below.**

**PERSON 2**

First Name* | MI | Last Name* | Gender* ☐ Male ☐ Female

Social Security Number* | Date of Birth (Month/Day/Year)* _____ | Relationship to You?* ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian

Tobacco Use?* ☐ Yes ☐ No

Which of the following best describes you?

☐ White or Caucasian ☐ Black or African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) ☐ Middle Eastern or North African ☐ Indian or Pakistani
☐ Northern Asian or Eastern European ☐ Other _____ ☐ Prefer not to answer

What is your ethnicity or ethnic background?

☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Other _____ ☐ Prefer not to answer

What is your preferred language?

☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

## STEP 4: SPOUSE/DEPENDENT(S) TO BE INSURED INFORMATION *(Continued)*

### PERSON 3

First Name* | MI | Last Name* | Gender* ☐ Male ☐ Female

Social Security Number* | Date of Birth (Month/Day/Year)* _____ | Relationship to You?* ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian

Tobacco Use?* ☐ Yes ☐ No

Which of the following best describes you?

☐ White or Caucasian ☐ Black or African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) ☐ Middle Eastern or North African ☐ Indian or Pakistani
☐ Northern Asian or Eastern European ☐ Other _____ ☐ Prefer not to answer

What is your ethnicity or ethnic background?

☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Other _____ ☐ Prefer not to answer

What is your preferred language?

☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

### PERSON 4

First Name* | MI | Last Name* | Gender* ☐ Male ☐ Female

Social Security Number* | Date of Birth (Month/Day/Year)* _____ | Relationship to You?* ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian

Tobacco Use?* ☐ Yes ☐ No

Which of the following best describes you?

☐ White or Caucasian ☐ Black or African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) ☐ Middle Eastern or North African ☐ Indian or Pakistani
☐ Northern Asian or Eastern European ☐ Other _____ ☐ Prefer not to answer

What is your ethnicity or ethnic background?

☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Other _____ ☐ Prefer not to answer

What is your preferred language?

☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

### PERSON 5

First Name* | MI | Last Name* | Gender* ☐ Male ☐ Female

Social Security Number* | Date of Birth (Month/Day/Year)* _____ | Relationship to You?* ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian

Tobacco Use?* ☐ Yes ☐ No

Which of the following best describes you?

☐ White or Caucasian ☐ Black or African American ☐ Native American or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian (e.g. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese) ☐ Middle Eastern or North African ☐ Indian or Pakistani
☐ Northern Asian or Eastern European ☐ Other _____ ☐ Prefer not to answer

What is your ethnicity or ethnic background?

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What is your preferred language?

☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

*Question is required and must be completed or your application will be delayed.

## STEP 5: SIGN, AUTHORIZE AND DATE APPLICATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively canceling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer may be guilty of a crime.

| X | |
|---|---|
| Applicant's Signature or Responsible Adult if Applicant is under age 18 | Date Signed |

| Producer Number | Producer Name | Producer Signature |
|---|---|---|
| | | |

### Tobacco Use

You should answer "Yes" to the Tobacco Use question if you, your spouse or any of your Eligible Dependents (age 21 or older as of the requested effective date) have, within the past six months, used tobacco regularly (four or more times per week on average, excluding religious or ceremonial uses).

### Coverage Information

I understand if I pay any portion of my health insurance premiums using pretax dollars (Section 125) or my employer pays any portion of my health insurance premiums (Section 106) or provides reimbursement for uninsured medical expenses for me and my dependents (Section 162), I should answer "yes" to the question, "Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code?" (located in Section 2, Choose Your Plan).

### Who is eligible for the BlueEssential catastrophic plan?

The BlueEssential catastrophic plan may only be offered to individuals who are under age 30 as of the requested effective date.

### BlueDirect Benefit Plans

This overview describes a high deductible health plan designed to comply with Section 223 of the Internal Revenue Code and intended for use with a Health Savings Account (HSA)*. Blue Cross Blue Shield of North Dakota (BCBSND) is not authorized to provide legal or tax advice to members. BCBSND expressly disclaims responsibility for, and makes no representation or warranty regarding: (1) the eligibility of any member to establish or contribute to an HSA; or (2) the suitability of this product in all circumstances for use with HSAs.

*Note: cost-sharing reduction health plans purchased through the health insurance exchange may not comply for use with HSAs.

### Limitations and Exclusions

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

Must remain a North Dakota resident to maintain BCBSND coverage.

## Contact Us

**Visit us on the web:** www.BCBSND.com | **Member Services toll-free:** 844-363-8457

**Visit one of our offices:**

**Fargo Office**
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2232

**Bismarck Office**
1415 Mapleton Ave.
Bismarck, ND 58503
Phone: (701) 223-6348

**Jamestown Office**
300 2nd Ave. NE, Suite 132
Jamestown, ND 58401
Phone: (701) 251-3180

**Grand Forks Office**
3570 S. 42nd St., Suite B
Grand Forks, ND 58201
Phone: (701) 795-5340

**Minot Office**
1308 20th Ave. SW
Minot, ND 58701
Phone: (701) 858-5000

**Williston Office**
1137 2nd Ave. W., Suite 105
Williston, ND 58801
Phone: (701) 572-4535

In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

**Español (Spanish)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

**Deutsch (German)**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

**中文 (Chinese)**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

**Oroomiffa (Oromo)**

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

**Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

**Ikirundi (Bantu – Kirundi)**

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

**العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711 ).

**Kiswahili (Swahili)**

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

**Русский (Russian)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

**日本語 (Japanese)**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

**नेपाली (Nepali)**

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

**Français (French)**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

**한국어 (Korean)**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

**Tagalog (Tagalog – Filipino)**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

**Norsk (Norwegian)**

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

**Diné Bizaad (Navajo)**

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)