Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association

2027 North Dakota Individual Enrollment Application and Change Request Form

Thank you for considering Blue Cross Blue Shield of North Dakota (BCBSND) for your Individual health insurance coverage.

You can apply with this application or save time by shopping for a plan at BCBSND.com.

Please see Important Information page for information regarding eligibility, effective dates, and more.

Section 1: Application type

Check the boxes that apply to you. If you're applying outside of open enrollment, you must have a qualifying event (see Section 5: Qualifying events).

☐ **New application** ☐ **Plan change** ☐ **Add dependent**

Requested effective date for this policy

See Important Information page for effective date guidelines.

Section 2: Subscriber information (policy holder)

Last name	First name	M.I.	Social Security number	Gender ☐ Male ☐ Female ☐ Non-binary/Other
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)			Tobacco user ☐ Yes ☐ No

Residential street address	City	State	ZIP	County

Mailing address (if different from street address)	City	State	ZIP	County

Billing last name	Billing first name	Relationship to applicant

Billing address (if different from mailing address)	City	State	ZIP	County

BCBSND can provide a digital ID card via text when a mobile number is shared.		Email Email address
Phone number (xxx) xxx-xxxx	Alternate number (xxx) xxx-xxxx	BCBSND can communicate with you securely and efficiently when an email address is provided.

Section 2: Subscriber information (policy holder), continued

Texting application status
Only applicable if the applicant is 18 years or older.

By providing my phone number, I consent to receive application status updates via text message.

Phone number

Consent is not required as a condition of purchase.
By consenting, you authorize telemarketing through the use of an automatic dialing/texting system or artificial prerecorded message.

Do you spend more than 50% of your time outside of the state of North Dakota? ☐ Yes ☐ No	If yes, indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason

Will you have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy) (mm/dd/yyyy)	Type of coverage ☐ Employer group ☐ Individual ☐ Medicare ☐ Other (define)

Section 3: Family information

Please list the names of everyone who is eligible who you want to cover. A dependent can be your spouse or children under age 26 or a child of any age who is disabled. If you are applying for coverage for children only, please submit one application per child.

Last name	First name	M.I.	Social Security number	Gender ☐ Male ☐ Female ☐ Non-binary/Other

Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)	Tobacco user ☐ Yes ☐ No

Relationship: ☐ Spouse ☐ Dependent child under age 26 ☐ Disabled child

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy) (mm/dd/yyyy)	Type of coverage ☐ Employer group ☐ Individual ☐ Medicare ☐ Other (define)

Section 3: Family information, continued

Last name	First name	M.I.	Social Security number	Gender ☐ Male ☐ Female ☐ Non-binary/Other
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)			Tobacco user ☐ Yes ☐ No

Relationship: ☐ Dependent child under age 26 ☐ Disabled child

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy) (mm/dd/yyyy)	Type of coverage ☐ Employer group ☐ Individual ☐ Medicare ☐ Other (define)

Last name	First name	M.I.	Social Security number	Gender ☐ Male ☐ Female ☐ Non-binary/Other
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)			Tobacco user ☐ Yes ☐ No

Relationship: ☐ Dependent child under age 26 ☐ Disabled child

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy) (mm/dd/yyyy)	Type of coverage ☐ Employer group ☐ Individual ☐ Medicare ☐ Other (define)

Last name	First name	M.I.	Social Security number	Gender ☐ Male ☐ Female ☐ Non-binary/Other
Date of birth (mm/dd/yyyy) (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please define)			Tobacco user ☐ Yes ☐ No

Relationship: ☐ Dependent child under age 26 ☐ Disabled child

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy) (mm/dd/yyyy)	Type of coverage ☐ Employer group ☐ Individual ☐ Medicare ☐ Other (define)

If you have more dependents, print an additional Page 3 and include it with your application.

Section 4: Race and ethnicity

Review the lists below and provide applicant(s) name, ethnicity, and race. We use this data exclusively to improve services to our members. You do not have to answer these questions and giving us this information will not affect your eligibility, plan choices, or access to programs. If you have additional race and ethnicity information to provide, please print an additional Page 4 and include it with your application.

Applicant name	Ethnicity	Race	
	Cuban Guatemalan Hispanic or Latino/a Mexican, Mexican American, Chicano/a Puerto Rican Salvadoran Not Hispanic or Latino/a Other (please define) **Prefer not to answer**	American Indian or Alaska Native Asian Indian Black or African American Chinese Filipino Guamanian or Chamorro Japanese Korean	Native Hawaiian Other Asian Other Pacific Islander Samoan Vietnamese White Other (please define) **Prefer not to answer**

Section 5: Qualifying events

Complete Section 5 if you've had a life event that changes your coverage needs outside the open enrollment period. Check the box next to the situation that applies to you and include the requested documents. You must apply no more than 60 days after the date of the qualifying event.

If you're applying during open enrollment and not due to one of these situations, skip this section.

Date of event: (mm/dd/yyyy)	Loss of coverage date (if applicable): (mm/dd/yyyy)

(Your qualifying event date may not be the same as your effective date.)

Which of these applies to you?	Include the following proof document(s):
☐ You lost minimum essential coverage as defined in federal law, including, but not limited to, most government-sponsored programs (for example, Medicare, Medicaid, CHIP), employer-sponsored plans, and Individual plans in the state (except due to nonpayment of premium or fraud/intentional material misrepresentation).	• Employer letter on company letterhead, Certificate of Coverage or other proof of medical coverage termination reason. If this reason is due to divorce, please provide a copy of the filed divorce decree.

Section 5: Qualifying events, continued

Which of these applies to you?	Include the following proof document(s):
☐ You have a new dependent(s) through birth, adoption, or placement for adoption, or marriage. If marriage, you or your spouse also must have either: • had minimum essential coverage for at least one of the 60 days immediately before marriage or domestic partnership, or • been living in a foreign country or U.S. territory for at least one of the 60 days immediately before marriage, or be an Indian as defined in federal law.	• Copy of state issued birth certificate; adoption or placement papers; or marriage certificate. For marriage, provide a copy of the filed marriage certificate, plus one of the following, according to your situation: • Proof of medical coverage or other creditable coverage. • A copy of a utility bill in your name from your **prior address** dated within the last 60 days (if you got married and moved from a foreign country or U.S. territory). • Tribal ID card (if you are Indian as defined in federal law).

☐ You had a permanent move and:
• gained access to a new qualified health plan, and
• had minimum essential coverage for at least one day of the 60 days immediately before your move, or
• you were living in a foreign country or a U.S. territory immediately before your move
	• Proof of medical coverage or other creditable coverage.
	• A copy of a utility bill in your name from your **prior address** dated within the last 60 days.
	• Any two documents that show your home address:
	— A valid picture ID showing your home address:
	  • North Dakota driver's license
	  • North Dakota state-issued ID card
	  • Tribal ID card
	  • Military ID card
	— Utility bill for services received for your current residence (examples: gas, water or electric bill) not older than 60 days. Must include:
	  • date of service
	  • service address
	  • mailing address
	— Signed rental agreement for current residence (signed by the tenant and landlord)
	  • If you are submitting a month-to-month lease, it must be signed within 60 days of application
	— Current student enrollment or letter from college/university registrar noting residence address

☐ Other	• Please see BCBSND.com/go/ND/SEP or contact us for more information about other qualifying events and supporting documents to provide.

Section 6: Plan options

Below are the plan choices available to you based on your county of residence. Check one box to indicate your health plan selection. To learn more about the plans and networks, visit our website: BCBSND.com/go/plans

Network: Preferred Blue PPO

Counties available: statewide

- ☐ BlueDirect Gold 90 HSA Eligible $2600 Deductible**
- ☐ BlueDirect Silver 80 HSA Eligible $4000 Deductible**
- ☐ BlueDirect Silver LP 80 HSA Eligible $3800 Deductible**
- ☐ BlueDirect Bronze 100 HSA Eligible $8100 Deductible**
- ☐ BlueCare Silver LP $35 PCP Copay
- ☐ BlueCare Bronze HSA Eligible $50 PCP Copay**
- ☐ BlueValue Gold $30 PCP Copay
- ☐ BlueValue Silver $40 PCP Copay
- ☐ BlueValue Bronze HSA Eligible $50 PCP Copay**
- ☐ BlueEssential Catastrophic 100 HSA Eligible $12000 Deductible**

**HSA Compliant

Note: The BlueEssential Catastrophic plan may only be offered to individuals who are under age 30 as of the requested effective date. Individuals over the age of 30 may be eligible for a hardship exemption.

Counties available: Adams, Barnes, Billings, Bowman, Burleigh, Cass, Dickey, Dunn, Emmons, Foster, Golden Valley, Grant, Hettinger, Kidder, LaMoure, Logan, McIntosh, Mercer, Morton, Oliver, Ransom, Richland, Sargent, Sheridan, Sioux, Slope, Stark, Stutsman, Traill, Wells, Williams

- ☐ BlueCare Gold $10 PCP Copay
- ☐ BlueCare Silver $35 PCP Copay

Network: DakotaBlue Altru

Counties available: Benson, Cavalier, Eddy, Grand Forks, Griggs, Nelson, Pembina, Ramsey, Steele, Towner, Walsh

- ☐ DakotaBlue Altru Gold
- ☐ DakotaBlue Altru Silver
- ☐ DakotaBlue Altru Silver LP

Network: DakotaBlue Trinity

Counties available: Bottineau, Burke, Divide, McHenry, McKenzie, McLean, Mountrail, Pierce, Renville, Rolette, Ward

- ☐ DakotaBlue Trinity Gold
- ☐ DakotaBlue Trinity Silver
- ☐ DakotaBlue Trinity Silver LP

Health Savings Account (HSA) compliant health plan:

HSA compliant health plans, such as a high deductible health plan or an individual bronze health plan, can be paired with a separate health savings bank account.

To take advantage of the pre-tax savings offered by your HSA financial account from day one, we recommend you open your account by your health plan effective date.

An HSA option offers its most value when you set up its health savings account with a financial institution. You can use our preferred partner, HealthEquity®, or use any other institution. HealthEquity provides additional information via postal mail within 30 days after enrollment.

- ☐ Yes, I authorize BCBSND to share my eligibility and claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (Social Security number must be provided in Section 2).

  Terms and conditions of the health savings financial account will be mailed with your HealthEquity HSA Visa Card.

- ☐ No, do not share my information with HealthEquity. I have/will open my own HSA financial account.

Section 6: Plan options, continued

You must also designate a Primary Care Provider (PCP). List your choice of provider, their address and medical group name (if known):

Applicant name	PCP	Address	Medical group name

Section 7: Payment options

We offer two ways to pay your premium:

- ☐ Recurring electronic funds transfer (EFT) debits from a bank account to BCBSND. Please fill out the EFT authorization agreement. Recurring EFT entries occurs around the fifth of the month and typically takes one or two days to post to your account
- ☐ Monthly bill. If you select this option, we'll send you a bill every month. Once you are a member, create an account on BCBSND.com to pay with a debit or credit card.

Is any third-party payer paying for any portion of this policy?

☐ Yes ☐ No

If yes, please indicate payer type and payer name:

- ☐ Parent/Guardian/Relative
- ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

If ICHRA, name of employer

- ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

If QSEHRA, name of employer

- ☐ Employer
- ☐ Other

Indicate payer name or ICHRA/QSEHRA administrator name

If you indicate an ICHRA/QSEHRA as a payer, you may need to provide documentation of your ICHRA/QSEHRA arrangement.

Are you self-employed and planning to pay your premiums with your business account?

☐ Yes ☐ No

If Yes, what is the name of your business?

Note: We do not accept third-party payments from employers, providers and not-for-profit agencies unless required by law.

Section 7: Payment options, continued

EFT information (complete only if EFT is selected)

Authorization to my bank

I authorize BCBSND to charge my bank account for monthly premiums due on or after the coverage effective date. I also authorize my bank to honor these monthly charges. This authority remains in effect until I revoke it in writing and provide notice to BCBSND.

I understand and acknowledge that the amount debited may change based on the premiums due under my plan, and I authorize BCBSND to debit such amounts as permitted by applicable law.

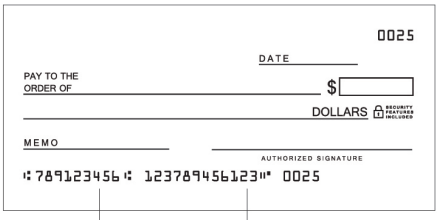
This authorization remains in effect until I revoke it in writing to the address on this form and provide notice to BCBSND at least five (5) business days before the proposed effective date of termination.

I understand my financial institution can answer questions about my rights.

Depending on the timing of your effective date, your first premium payment may have to cover multiple months. If more than one month's premium is due for the first draft, do you authorize BCBSND to pull the full amount from your account?

☐ **Yes** ☐ **No**

If No, you are not eligible for EFT right away. You can enroll in EFT and provide your bank information at a later time.



Transit/ routing number

Account number

Financial institution or bank	**Transit/routing number**	**Account number**

Account holder's name (please print)	**Check one:** ☐ Checking account ☐ Savings account

Account holder's relationship	**Account holder's signature**	**Date** (mm/dd/yyyy)

Section 8: Signatures

You must sign this application. All signatures apply to "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information."

Certification of Completion and Correctness

- I affirm that the answers given in this application are complete and correct.
- I have provided these answers as part of the application procedure required by BCBSND to enroll in its insurance coverage.
- I understand that if this application contains any intentional misrepresentations of material fact, BCBSND may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action.
- I further understand that if the misrepresentation amounts to fraud, BCBSND may deny coverage, modify or cancel the contract, or take other legal action even after the first two years of coverage.
- I will promptly inform BCBSND in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect.
- I understand and agree that no coverage shall be in force until approved by BCBSND.

Section 8: Signatures, continued

- If approved, coverage will be in force as of the effective date determined by BCBSND.
- BCBSND may contact me to clarify answers on this application.
- As the applicant, I understand I have the right to inspect the information in my file.
- I further affirm that I received a disclosure statement from BCBSND or its authorized insurance provider.
- I understand that if I answered "No" to being a tobacco user and my answer changes to "Yes" any time after submitting this application, I must notify BCBSND. A surcharge will be applied.*
- If applicable, BCBSND has permission to contact any employer, plan, or carrier regarding any details related to an assertion of special enrollment rights.

Authorization for Use and Disclosure of Protected Health Information

I understand that BCBSND may request or disclose health information about me or my covered dependents for the purpose of facilitating health care, payments or benefit administration, or as required by law.

This health information may be related to treatment or services performed by:

- A doctor, dentist, pharmacist or other physical or behavioral health care practitioner
- A clinic, hospital, long-term care or other medical facility
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies
- Another insurance carrier or health plan

Health information may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, lab reports, dental records, or hospital records (including nursing records and progress notes). This authorization may not be used for psychotherapy notes; such notes will require a separate authorization.

For more information, please see the BCBSND Consumer Privacy Notice available at BCBSND.com or by calling 1-833-215-9541.

If adult subscriber age 18 and over and applying for Individual or family coverage, complete this section. If signing as a personal representative, please skip to the last section.	
Signature of subscriber	Date (mm/dd/yyyy)

If child-only subscriber under the age of 18, complete this section.	
Print name of responsible party	
Signature of responsible party	Date (mm/dd/yyyy)
Relationship ☐ Parent ☐ Power of Attorney* ☐ Legal Guardian*	

*A surcharge is applied to your premium for each person covered by your plan who uses tobacco. If we receive false information about tobacco usage or if you fail to notify BCBSND of a change in tobacco usage, BCBSND can collect unpaid surcharges and take any other available action.

Section 8: Signatures, continued

If personal representative* for an applicant age 18 and over, complete this section.	
Who are you signing for?	
Print name of responsible party	
Signature of responsible party	Date (mm/dd/yyyy)
Relationship ☐ Parent ☐ Power of Attorney* ☐ Legal Guardian* *Please send legal documentation proving relationship	

Section 9: Comments

Please explain any unique circumstances that may affect your application or provide your thoughts on how we can serve you better.

Section 10: For producer use only

I (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by BCBSND. I have informed the applicant that the effective date of coverage is assigned only by BCBSND. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**

Name (please print or type)	Producer number	
Mailing address	Email Email address	Phone number (xxx) xxx-xxxx

Congratulations you're almost done!
Mail or email this form to Blue Cross Blue Shield of North Dakota.

Mail:
Blue Cross Blue Shield of North Dakota
Attn: Underwriting
P.O. Box 1106
Lewiston, ID 83501-1106

Email:
IndElig@BCBSND.com

Questions?
Talk to your producer/agent or call us at 1-833-215-9541.

New to Blue Cross Blue Shield of North Dakota?
You'll receive a letter with your member ID number to get started on BCBSND.com.

Important Information

Effective dates:

- Your application is subject to review and approval by BCBSND. Complete applications received in our office by midnight on the last day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.
- We may have to change the start date you request based on your eligibility. Your rates may change depending upon your preferred effective date. Specific special enrollment qualifying events such as birth or adoption require that coverage begins on the date of the event. Coverage is not guaranteed.

Application support:

- If you want to buy coverage through the Marketplace, go to Healthcare.gov.
- If you need help completing your application or have questions, contact your insurance producer (agent) or call us at 1-833-215-9541.
- To change to a new plan, your premium payments must be up to date. If your policy is canceled because your premium wasn't paid, you will need to send us a new application.
- If any enrolling family member has other coverage in addition to BCBSND, we may coordinate benefits between the multiple health plans.
- A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past six months.
- If you are eligible for and have enrolled in an Individual policy, your contract may contain a Coordination of Benefits (COB) provision. We depend on your help in order for us to process your claims correctly. If you have other coverage that overlaps with your new Individual policy, please contact Customer Service.

You can apply for Individual health coverage if you are both:

- A resident of North Dakota, with a primary residence in North Dakota for at least 6 months each year.
- Not enrolled in a Medicare plan. Additionally, any dependent enrolled in a Medicare plan will not be eligible for coverage under this Policy. If you're 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.

You can include these dependents on your plan:

- Your spouse
- Your or your spouse's children (including children placed with either of you for adoption, or adopted by either of you) under age 26
- Children who you or your spouse are legally required to cover due to a qualified medical child support order
- Your or your spouse's disabled children age 26 or over. (We will need a copy of the "Medical Certification of Disability for Disabled Children" form, available on BCBSND.com)

When can you apply?

- Open enrollment: Every fall, North Dakota holds open enrollment for individuals applying for coverage to start thefollowing January 1st or thereafter. You can find this year's dates on BCBSND.com. We need to receive your application during open enrollment.
- Special enrollment: You can apply outside open enrollment if you have a qualifying life event (like a birth or amarriage) that changes your coverage needs. See Section 5 to learn more.

Compensation disclosure:

- BCBSND may provide producers with bonuses, commissions, administrative fees or other compensation (including non-cash compensation). Incentives may be based on factors such as the products you buy, the producer's volume of business with BCBSND, and other services. These incentives may have an indirect impact on your rates. If you would like to see our compensation structure, please visit BCBSND.com/go/agentcompdisclosure.

Race, ethnicity and language:

- We are committed to advancing health equity for our members. Obtaining race, ethnicity and language information can help us reach and possibly bridge healthcare gaps in traditionally under-served communities.