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. 11/1/2025
Filed 10/2/2025
BND-22-0059565 IND FI
10-25

STEP 1: REASON FOR APPLYING

Please note: Member ID is a requirement only if changing existing coverage with BCBSND

☐ New Coverage (I do not have BCBSND coverage now) | Previous Health Carrier _____

☐ Change in Existing BCBSND Coverage | Coverage End Date _____ | Member ID _____

STEP 2: 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

*Please provide at least one phone number below**

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 3: CHOOSE YOUR PLAN

Benefit Plans:

☐ **BlueDirect Gold 90 HSA Eligible (10914784)**
- ($2,600 Deductible / $5 Preventive Drug List)

☐ **BlueDirect Silver 80 HSA Eligible (10914785)**
- ($3,500 Deductible / $5 Preventive Drug List)

☐ **BlueDirect Silver LP 80 HSA Eligible (10914790)**
- ($3,400 Deductible / $5 Preventive Drug List)

☐ **BlueDirect Bronze 100 HSA Eligible (10914786)**
- ($8,000 Deductible / $5 Preventive Drug List)

☐ **BlueCare Gold $10 PCP Copay (10914787, 10914801)**
- ($5 Value Based Drug List)

☐ **BlueCare Silver $20 PCP Copay (10914788)**
- ($5 Value Based Drug List)

☐ **BlueCare Silver LP $20 PCP Copay (10914791)**
- ($5 Value Based Drug List)

☐ **BlueCare Bronze HSA Eligible $50 PCP Copay (10921939)**
- ($5 Value Based Drug List)

☐ **BlueEssential Catastrophic 100 HSA Eligible (10914789)**
- ($10,600 Deductible)

☐ **BlueValue Gold $30 PCP Copay (10914792)**
- (Standardized plan)

☐ **BlueValue Silver $40 PCP Copay (10914793)**
- (Standardized plan)

☐ **BlueValue Bronze HSA Eligible $50 PCP Copay (10914794)**
- (Standardized plan)

☐ **DakotaBlue | Altru Gold (10914796)**
- ($5 Value Based Drug List)

☐ **DakotaBlue | Altru Silver (10914797)**
- ($5 Value Based Drug List)

☐ **DakotaBlue | Altru Silver LP (10914795)**
- ($5 Value Based Drug List)

☐ **DakotaBlue | Trinity Gold (10914800)**
- ($5 Value Based Drug List)

☐ **DakotaBlue | Trinity Silver (10914799)**
- ($5 Value Based Drug List)

☐ **DakotaBlue | Trinity Silver LP (10914798)**
- ($5 Value Based Drug List)

STEP 3: 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 (insert name below) with this application.
Employer Name* _____

☐ Yes ☐ No Do you have an Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) through your employer?
If yes, please provide a copy of the notice you received from your employer (insert name below) with this application.
Employer Name* _____

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

STEP 4: QUALIFYING LIFE EVENT

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
- ☐ Current Policyholder 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
☐ QSEHRA	Notice received from your employer

STEP 5: SPOUSE/DEPENDENT(S) TO BE INSURED INFORMATION

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

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?

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☐ 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?

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☐ 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

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?

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

What is your preferred language?

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

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STEP 6: 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).

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. Individuals over the age of 30 may be eligible for a hardship exemption. Please contact BCBSND Sales.

Qualified High Deductible Health Plans

Plans designated above as HSA Eligible 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.

I understand that I must remain a North Dakota resident to maintain BCBSND coverage.

Contact Us

Visit: **www.BCBSND.com/contact** to schedule an appointment with a BCBSND sales team member.

Call: Member Services toll-free: **844-363-8457** | Sales: **800-280-2583**

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South • Fargo, ND 58121

Blue Cross Blue Shield of North Dakota (BCBSND) 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. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- 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 and 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 BCBSND 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) (unencrypted emails present 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 Ave. S.W. 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 con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

Deutsch (German) – ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-844-363-8457 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

中文 (Chinese) – 注意：如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-363-8457（聽障服務專線TTY：1-800-366-6888 或 711）或與您的醫療服務提供者討論。

Oromoo (Oromo) – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-844-363-8457 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

Ikirundi (Bantu – Kirundi) – Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw'inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-844-363-8457 (TTY: 1-800-366-6888 canke 711) canke uvugane n'ujejwe kugufasha.

العربية (Arabic) – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من دون أي تكلفة. اتصل على الرقم: 1-844-363-8457 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

Kiswahili (Swahili) – ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

Русский (Russian) – ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-844-363-8457 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) – お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-844-363-8457（TTY：1-800-366-6888 または 711）にお電話いただくか、医療提供者にご相談ください。

नेपाली (Nepali) – ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-844-363-8457 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Français (French) – ATTENTION : Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

한국어 (Korean) – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-844-363-8457(TTY: 1-800-366-6888 또는 711)번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

Tagalog (Tagalog) – PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

Norsk (Norwegian) – OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ'ÁT'ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłti'go, t'áá íiyisí t'áá bee yáhoot'éél dóó baa áháyá' át'é. T'áá jíík'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilį́į'ígíí t'áá jíík'ehgo bee hóló, dóó t'áá íiyisí doo béésh bee hadooleeł da. 1-844-363-8457 bee hojiiį' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodool'į'.