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. 1/1/2020
Filed 3/23/2018
29378831 IND FI
POD • 7-19

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 _____ /_____ /_____
Mailing Address			
City	State	ZIP	County / State in which you reside
Home Phone	Work Phone		Mobile Phone
Email Address (If applicable)			
Tobacco Use?* ☐ Yes ☐ No			

*Question is required and must be completed or your application will be delayed. See back page for further clarification.

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:

- ☐ BlueDirect Gold 90 **(10353824)**
- ☐ BlueDirect Silver 80 3000 **(10353825)**
- ☐ BlueDirect Silver 80 2800 **(10430436)**
- ☐ BlueDirect Bronze 100 **(10353826)**
- ☐ SimplyBlue Bronze 60 **(10353827)**
- ☐ BlueCare Gold 70 **(10353828)**
- ☐ BlueCare Silver 70 5000 **(10353829)**
- ☐ BlueCare Silver 70 4200 **(10430437)**
- ☐ BlueEssential **(10353830)**

☐ 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, 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

Loss of previous health coverage due to:

- ☐ Legal Separation/Divorce
- ☐ Death
- ☐ Termination of Employment/Reduction of Hours
- ☐ Employer Contribution Terminated
- ☐ Other _____

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

Life Event:	Supporting documentation required:
☐ Annual Enrollment	None
☐ Marriage	Marriage certificate
☐ Birth	Birth certificate
☐ Adoption	Adoption papers
☐ Legal Guardianship	Legal Guardianship papers

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

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

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

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

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

*Question is required and must be completed or your application will be delayed. See back page for further clarification.

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 is 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 18 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.

Contact Us

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

Visit one of our offices:

Home Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (844) 363-8457

Fargo District Office
4510 13th Ave. S.
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Phone: (701) 277-2232

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Grand Forks, ND 58201
Phone: (701) 795-5340

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1674 15th St. W., Suite D
Dickinson, ND 58601
Phone: (701) 225-8092

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

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1308 20th Ave. SW
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Phone: (701) 858-5000

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425 College Dr. S., Suite 13
Devils Lake, ND 58301-3537
Phone: (701) 662-8613

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

Williston Office
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Williston, ND 58801
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