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

Blue Cross Blue Shield of North Dakota
Return form to: BCBSND Representative
Fax form to: 1-866-303-5117

2027 Application for Enrollment/Change (for groups 101+)

Please print in black ink. Incomplete or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.**

GROUP ADMINISTRATOR: This section should be completed by the Group Administrator.				
Group Number	Subgroup	Class	Group Name	Requested Effective Date
Hours Per Week	Original Date of Hire	Full Time Date of Hire	Eligibility Waiting Period Start Date	

SECTION 1 – NEW ENROLLMENT, CHANGE OR TERMINATION (Please populate all fields)

Employee Last Name		First Name		Middle Initial
Employee Mailing Address		City	State	ZIP
Employee Physical Address (same as mailing ☐)		City	State	ZIP
Primary Language	Daytime Phone Number	Email Address - to receive important information		

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced

New Enrollment/Termination

Date of Event: _____

☐ New Group/New Hire

☐ Open Enrollment

☐ Rehire

☐ Termination

Special Enrollment

Date of Event: _____

☐ Birth/Adoption

☐ Loss of Coverage (complete Section 5)

☐ Marriage

☐ Other _____

Changes

☐ Name Change

New Name: _____

Old Name: _____

☐ Address Change (enter above)

☐ Plan Selection

SECTION 2 – PLAN SELECTION

Refer to your Group Administrator for plan options available to you.

Dental	Vision
☐ Dental ☐ No Dental	☐ Vision ☐ No Vision

Medical

Select a medical plan, then select a network from the same row. Not all networks are available for each medical plan.

Networks				
Medical Plans	Preferred Blue (PPO)	DakotaBlue Altru	DakotaBlue Trinity	DakotaBlue
☐ YourBlue	☐	N/A	N/A	N/A
☐ BlueSaver PPO (HDHP)	☐	N/A	N/A	N/A
☐ DakotaBlue HDHP	N/A	☐	☐	☐
☐ DakotaBlue	N/A	☐	☐	☐
☐ BlueAccess	☐	N/A	N/A	N/A
☐ No Medical				

For groups offering more than one medical plan, enter the deductible amount of the plan selected:

\$ _____



SECTION 2 – PLAN SELECTION (continued)

HSA (health savings account) health plans only: If your employer has partnered with HealthEquity for your HSA bank account, it will be created for you automatically. No further action is required from you; however, you have the following alternative options:

- ☐ Send my claims data to HealthEquity. I have read and agreed to the *HSA Authorization Form* (located on bcbsnd.com).
- ☐ No, I don't want a HealthEquity HSA.

SECTION 3 – ENROLLING MEMBERS

List all members for whom you are adding, changing or terminating Medical (M) or Dental (D) benefits.

Add	Term	Benefit	Gender	Name (First, Middle, Last)	Social Security Number	Date of Birth	Relation**
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*	Employee/Subscriber			SELF
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				

*O = Non-binary/Other

**Spouse, Domestic Partner, Child, Stepchild, Grandchild, Adopted^, Legal Guardian^

^Additional paperwork required

This confirms that any employee or dependent for whom retroactive termination for administrative delay is requested had no expectation of coverage and paid no premium after the requested termination date.

Group Administrator Signature: _____ **Date:** _____

SECTION 4 – COBRA OR NON-COBRA CONTINUATION ENROLLMENT

You or your dependents may be entitled to COBRA or Non-COBRA continuation due to loss of current coverage. Select an option for continuing coverage below, or select "None" if not electing.

Reasons for entitlement include loss of coverage due to: Termination of employment; Enrolled child no longer eligible; Medicare entitlement; Reduction of hours; Divorce; Death.

Type of Continuation: ☐ COBRA ☐ Non-COBRA Continuation ☐ None

Reason for Entitlement: _____ Date of Event: _____

SECTION 5 – CURRENT AND PRIOR COVERAGE

Names of Covered Members	Health Insurance Carrier	Dates of Coverage	Coverage Continuing?	Coverage and Product Type
	Carrier Name:	Begin:	☐ Yes	Coverage Type: ☐ Group ☐ Individual
	Policy Number:	End:	☐ No	Product Type: ☐ Medical ☐ Dental
	Carrier Phone:			Medicare: ☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

Note: If coverage is provided for an enrolled child or children from a previous marriage or relationship, please attach a copy of any court documentation that shows who is responsible for the health care expenses or insurance of the child(ren) so that the carrier can determine which coverage should pay first.

If you need extra space, please request an additional form from your group administrator.

SECTION 6 – APPLICANT SIGNATURE

I have reviewed and agree to the provisions set out in Section 7 – Acknowledgments and Authorizations below.

Applicant Signature: _____ Date: _____



SECTION 7 – ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or termination of coverage as indicated above. Any coverage will be under the master contract between BCBSND and my employer and subject to the terms and conditions of the certificate issued under it. I agree to the employer's enrollment provisions and certify that those I seek to enroll meet the eligibility criteria. I understand that coverage does not start until I serve the employer's eligibility waiting period established in BCBSND's records.

I waive coverage of any eligible individual not listed on this application. I, or any other waived individual, may enroll at a later time during my group's annual open enrollment period or a Special Enrollment Period. If I waive enrollment for myself or any of my dependents because of other health insurance coverage, I may enroll the waived individuals if I request enrollment within 30 days after the other health coverage ends, or within 60 days if I or my dependents lose eligibility for Medicaid or a state children's health insurance program (CHIP), or become eligible for premium assistance under Medicaid or CHIP. In addition, I may enroll myself or new dependents within 30 days of marriage, or within 60 days of birth, adoption, or placement for adoption if I wish to continue coverage beyond the first 31 days. Additional special enrollment rights may apply as required by law. Please call 1 (800) 505-6801 for more information about these rules.

This application will become part of the contract between BCBSND and my employer and I understand only an officer of BCBSND may change the terms of the master contract, its amendments, or this application. I acknowledge and agree that my employer may perform enrollment, eligibility-related, and other administrative tasks necessary to administer my group coverage, and acknowledge that my employer is in no way an agent for BCBSND. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I understand that, as permitted by law, BCBSND may obtain information necessary to verify eligibility and enrollment, to process claims, and administer coverage for me and my enrolled dependents. I acknowledge and understand that BCBSND may request or disclose health information, other than psychotherapy notes (for which a separate authorization will be used), about me or my enrolled dependents from time to time to facilitate health care treatment or payment, to assist with business operations necessary to administer health care benefits, or as required by law. More information about BCBSND's uses and disclosures of information is provided in its Notice of Privacy Practices, available at bcbnsd.com or by calling customer service.

I certify that all information provided on this form is true, correct, and complete and understand BCBSND will rely on it in making coverage and rating determinations. For the protection of all members, fraud or misrepresentation of material fact by me for the purpose of defrauding BCBSND may result in BCBSND taking any action allowed by law or contract, including termination or rescission of coverage or denial of benefits, or could subject me to prosecution for insurance fraud.



Race and Ethnicity Survey

We are committed to advancing health equity for our members. Obtaining race and ethnicity information can help bridge healthcare gaps in traditionally underserved communities.

The race and ethnicity information provided will be exclusively used to improve services to our members. Answers are not required, and information provided will not affect member eligibility, plan choices, or access to programs.

Employee/Subscriber Name	Group Name	Group Number

☐ Check this box if the Race and Ethnicity responses would be the same for the Employee/Subscriber and any active enrolled family members.

Race and Ethnicity Survey

Employee/Subscriber Name:

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

Dependent Name

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

Dependent Name

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



Race and Ethnicity Survey (Continued)

Employee/Subscriber Name		Group Name	Group Number
Dependent Name			
Race		Ethnicity	
☐ American Indian/ Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean		☐ Vietnamese ☐ Native Hawaiian ☐ Samoan ☐ White ☐ Other Asian ☐ Other Pacific Islander ☐ Other (please define) ☐ Prefer not to answer	
		☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Salvadoran ☐ Other ☐ Prefer not to answer	
Dependent Name			
Race		Ethnicity	
☐ American Indian/ Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean		☐ Vietnamese ☐ Native Hawaiian ☐ Samoan ☐ White ☐ Other Asian ☐ Other Pacific Islander ☐ Other (please define) ☐ Prefer not to answer	
		☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Salvadoran ☐ Other ☐ Prefer not to answer	
Dependent Name			
Race		Ethnicity	
☐ American Indian/ Alaskan Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean		☐ Vietnamese ☐ Native Hawaiian ☐ Samoan ☐ White ☐ Other Asian ☐ Other Pacific Islander ☐ Other (please define) ☐ Prefer not to answer	
		☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Salvadoran ☐ Other ☐ Prefer not to answer	

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 1-833-220-7903 (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 1-833-220-7903. 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 1-833-220-7903 (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 1-833-220-7903 (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 1-833-220-7903（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 1-833-220-7903 (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 1-833-220-7903 (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 1-833-220-7903 (TTY: 1-800-366-6888 canke 711) canke uvugane n’ujewe kugufasha.

(Arabic) العربية – 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: 1-833-220-7903 (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 1-833-220-7903 (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 1-833-220-7903 (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。1-833-220-7903 (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। 1-833-220-7903 (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 1-833-220-7903 (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. 1-833-220-7903 (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 1-833-220-7903 (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 1-833-220-7903 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ’ÁT’ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłt’go, t’áá íiyisí t’áá bee yáhoot’éél dóó baa áháyá’ át’é. T’áá jíík’ehígíí bee na’ách’aq’ holne’ dóó t’áá shikaadéé’ danilí’ígíí t’áá jíík’ehgo bee hólq, dóó t’áá íiyisí doo béesh bee hadooleet da. 1-833-220-7903 bee hojii’ (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane’ígíí nihił ch’á hodooll’j’.