ND

DCN

Health Benefit Plan
Affiliation and Out-of-Area Waiver Form

(Please type or print in black ink)

Section 1 - Affiliation:

Please indicate the Network name you have chosen for you and your Eligible Dependents.

Network Name _____

Section 2 - Out-of-Area Waiver:

Eligible Dependent children of the Subscriber or of the Subscriber's living, covered spouse are eligible for this waiver if:

- They reside at a facility for children with disabilities or other special needs (Anne Carlsen School, etc.);
- They reside outside the Network Service Area.

I certify my Eligible Dependent children listed below meet at least one of the above requirements. I understand all Covered Services received will be reimbursed at the In-Network benefit level.

Child's Name	Birth Date *(mm-dd-yy)*	Resides at a special needs facility	Dependent child residing Out-of-Area
Address:	– –	☐	☐
Address:	– –	☐	☐
Address:	– –	☐	☐
Address:	– –	☐	☐

I understand my Eligible Dependents and I must receive care within the Network I have selected, with the exception of Eligible Dependent children listed in **Section 2 - Out-of-Area Waiver**. Use of providers outside my Network will result in a reduction of benefits, unless an Authorized Referral has been obtained or the Out-of-Area Waiver is in effect.

Requested Effective Date: _____

Employer Name: _____

Employee Name: Last _____ First _____ M.I. _____

Employee Benefit Plan Number: _____

Employee Work Phone Number: ( ) – _____ Home Phone Number: ( ) – _____

Employee's Signature: _____ Date: _____

Spouse's Signature (if to be insured): _____ Date: _____

Send completed form to: Blue Cross Blue Shield of North Dakota, Underwriting Department
4510 13th Avenue S., Fargo, ND 58121

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

Noridian Mutual Insurance Company