



ND

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.

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

Noridian Mutual Insurance Company

Eff. 7/1/2018
Filed 3/23/2018
29378831 IND FI
POD • 10 -18

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 | <input type="checkbox"/> Male | <input type="checkbox"/> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> 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.

| | |
|--|---|
| <p>Benefit Plans:</p> <p><input type="checkbox"/> BlueDirect Gold 90 (10353824)</p> <p><input type="checkbox"/> BlueDirect Silver 80 3000 (10353825)</p> <p><input type="checkbox"/> BlueDirect Silver 80 2700 (10430436)</p> <p><input type="checkbox"/> BlueDirect Bronze 100 (10353826)</p> <p><input type="checkbox"/> SimplyBlue Bronze 60 (10353827)</p> <p><input type="checkbox"/> BlueCare Gold 70 (10353828)</p> <p><input type="checkbox"/> BlueCare Silver 70 5000 (10353829)</p> <p><input type="checkbox"/> BlueCare Silver 70 4200 (10430437)</p> <p><input type="checkbox"/> BlueEssential (10353830)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> 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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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.)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B?</p> |
|--|---|

STEP 3: REASON FOR APPLYING

New coverage (I do not have BCBSND coverage now) Change in existing BCBSND coverage

| | | |
|--|--|--|
| <p>Loss of previous health coverage due to:</p> <p><input type="checkbox"/> Legal Separation/Divorce</p> <p><input type="checkbox"/> Death</p> <p><input type="checkbox"/> Termination of Employment/Reduction of Hours</p> <p><input type="checkbox"/> Employer Contribution Terminated</p> <p><input type="checkbox"/> Other _____</p> <p>Termination letter from previous carrier identifying the reason for loss of coverage is required.</p> | <p>Life Event:</p> <p><input type="checkbox"/> Annual Enrollment None</p> <p><input type="checkbox"/> Marriage Marriage certificate</p> <p><input type="checkbox"/> Birth Birth certificate</p> <p><input type="checkbox"/> Adoption Adoption papers</p> <p><input type="checkbox"/> Legal Guardianship Legal Guardianship papers</p> | <p>Supporting documentation required:</p> |
|--|--|--|

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

PERSON 2

| | | | | | |
|--|--|----------------------|-------------------------------------|----------------------------------|---|
| First Name | MI | Last Name | Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Social Security Number: | Date of Birth (Month/Day/Year) ____/____/____ | Relationship to You? | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Stepchild |
| | | | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Adopted | <input type="checkbox"/> Legal Guardian |
| Tobacco Use?* <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

PERSON 3

| | | | | | |
|--|--|----------------------|-------------------------------------|----------------------------------|---|
| First Name | MI | Last Name | Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Social Security Number: | Date of Birth (Month/Day/Year) ____/____/____ | Relationship to You? | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Stepchild |
| | | | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Adopted | <input type="checkbox"/> Legal Guardian |
| Tobacco Use?* <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

PERSON 4

| | | | | | |
|--|--|----------------------|-------------------------------------|----------------------------------|---|
| First Name | MI | Last Name | Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Social Security Number: | Date of Birth (Month/Day/Year) ____/____/____ | Relationship to You? | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Stepchild |
| | | | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Adopted | <input type="checkbox"/> Legal Guardian |
| Tobacco Use?* <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

PERSON 5

| | | | | | |
|--|--|----------------------|-------------------------------------|----------------------------------|---|
| First Name | MI | Last Name | Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Social Security Number: | Date of Birth (Month/Day/Year) ____/____/____ | Relationship to You? | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Stepchild |
| | | | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Adopted | <input type="checkbox"/> Legal Guardian |
| Tobacco Use?* <input type="checkbox"/> Yes <input type="checkbox"/> 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

Dickinson Office

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

Devils Lake Office

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

Fargo District Office

4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2232

Bismarck District Office

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

Jamestown Office

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

Grand Forks District Office

3570 S. 42nd St., Suite B
Grand Forks, ND 58201
Phone: (701) 795-5340

Minot District Office

1308 20th Ave. SW
Minot, ND 58701
Phone: (701) 858-5000

Williston Office

1137 2nd Ave. W., Suite 105
Williston, ND 58801
Phone: (701) 572-4535