Individual Membership Application

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

DCN

29300945 Rev. 1-12

BPN_____

Please type or print in black ink. Press firmly.

Individual Membership Application

1. APPLICANT'S INFORMATION

GROUP ROLL _____

Last Name	First	M.I.	Social Security Number
			– –

Mailing Address	State in Which You Reside	Home Phone
		( ) –
City / State / Zip Code		Work Phone ( ) –

Marital Status	Sex	Birth Date (mm-dd-yy)	Height	Weight (lbs)
☐ Single ☐ Married ☐ Divorced ☐ Widowed (Give date if changing Marital Status) – –	☐ M ☐ F	– –	_____ft _____ in	

Requested Effective Date (mm-dd-yy)	Applicant's Employer	Occupation
– –		

2. SPOUSE/DEPENDENT INFORMATION *(Use extra paper if necessary)* *If applying for AffordaBlue, DO NOT complete this section.*

- List all family members to be covered, other than yourself. Indicate their relationship to you (i.e. child, stepchild, adopted, legal guardian, grandchild).
- Indicate dependent's address below dependent's name if the address is different from yours.
- **If Marital Status is Single and you are applying for coverage for your Eligible Dependent(s), you are required to attach a copy of the state birth certificate for each dependent unless previously submitted.**

First Name / M.I. / Last *(if different)*	Relationship	Sex	Birth Date *(mm-dd-yy)*	Height (ft & in)	Weight (lbs)	Active Military	Married	Court Ordered Coverage	Social Security Number
	SPOUSE	☐ M ☐ F	– –			☐ Yes ☐ No	N/A	N/A	– –
Address:		☐ M ☐ F	– –			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:		☐ M ☐ F	– –			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –

3. COVERAGE INFORMATION

☐ 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.)

HEALTH (BCBSND) coverage:

☐ New Coverage (I do not have BCBSND coverage now)
☐ Change in Existing BCBSND Coverage

Benefit Plans: ***(*you must complete section 3A)*** **Deductible**

☐ Comprehensive Major Medical 80* ..... $ _____
☐ Comprehensive Major Medical 60* ..... $ _____
☐ Personal Choice 80* ..... $ _____
☐ Personal Choice 60* ..... $ _____
☐ AffordaBlue* ..... $ _____
(see back page "Eligibility Requirements for AffordaBlue")
☐ Blue Saver 100* ..... $ _____
(see back page "Blue Saver Benefit Plan" for additional explanation)
☐ Blue Saver 80* ..... $ _____
(see back page "Blue Saver Benefit Plan" for additional explanation)
☐ Personal Choice for Students ..... $ _____
(see back page "Eligibility Requirements for Personal Choice for Students")
☐ Standard Plan ..... $ _____
☐ Basic Plan ..... $ _____
☐ Conversion ..... $ _____
☐ Basic Conversion ..... $ _____

I am applying for:

☐ Single Coverage = myself only
If married, is your spouse covered by an employer sponsored group health benefit plan? ☐ Yes ☐ No If no, must apply for Family Coverage.
☐ Single Plus Dependent Coverage = myself and eligible children
If married, is your spouse covered by an employer sponsored group health benefit plan? ☐ Yes ☐ No If no, must apply for Family Coverage.
☐ Family Coverage = myself and spouse **OR** myself, spouse and eligible children

3A. Automatic Payment Withdrawal *(Include Voided Check)*

Payment may be made by automatic payment withdrawal; however, **automatic payment withdrawal is mandatory for products identified with an asterisk (*).**

Name as Shown on Account (*print*) _____

Name of Financial Institution _____

City _____

Bank Routing Number
(first 9 digits on lower left side of check) _____

Account Number _____

☐ Checking Acct. ☐ Savings Acct. **Is this a Business Account?** ☐ Yes ☐ No

I hereby authorize my financial institution to deduct the current premium from my checking or savings account and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing. A 31-day notice is needed when cancelling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in my account.

Authorized Signature as Shown on Account _____
Retain a copy of this authorization for your records.

4. OTHER COVERAGE INFORMATION *(Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. FAILURE TO PROVIDE DOCUMENTATION MAY AFFECT YOUR WAITING PERIOD.)*

Other Health Benefit Plan including BCBSND coverage/Publicly Sponsored Program

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents **currently** or **previously covered** by another health benefit plan(s)? If yes, please complete this section.

Other Coverage Name	Other Coverage Phone Number	Policy Number	Policyholder *(first, m.i., last name)*	Birth Date *(mm-dd-yy)* – –

Policy Coverage Dates *(mm-dd-yy)*
From ___ – ___ – ___ **to** ___ – ___ – ___

Name(s) of Person(s) Covered

☐ Yes ☐ No Does this coverage provide maternity benefits?
☐ Yes ☐ No Do you intend to keep your current policy in force after the effective date of this application? **If not, why?**_____

Medicare

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently or previously enrolled in Medicare? If yes, please complete this section.

Name(s) of Person(s) enrolled in Medicare	Medicare Claim Number *(include alpha characters as shown on Medicare card)*

Hospital Part A Effective Date	Medical Part B Effective Date	Prescription Drug Part D Effective Date
☐☐-01-☐☐	☐☐-01-☐☐	☐☐-01-☐☐

Workers' Compensation/No-Fault

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently receiving or have received workers' compensation benefits?
☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently receiving or have received no-fault benefits?

Person's Name	Injury Date *(mm-dd-yy)* – –	Type of Injury	Company Providing Benefits	Company Phone Number

5. HEALTH INFORMATION **Members under age 19 do not complete this section if applying during the Annual Enrollment Period of May 1-31.**

In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Has any person named on this application ever had, been treated or diagnosed for:

	Yes	No	
1.	☐	☐	Anemia, leukemia or any blood disorder
2.	☐	☐	Any disability, injury or bodily deformity
3.	☐	☐	Any physical impairment or condition requiring periodic or long-term follow-up such as cerebral palsy, multiple sclerosis, muscular dystrophy, etc.
4.	☐	☐	Arthritis or rheumatism
5.	☐	☐	Asthma, emphysema, COPD, any lung disease, sleep apnea or use of a CPAP machine
6.	☐	☐	Cancer, tumor or any abnormal growth (malignant or non-malignant)
7.	☐	☐	Diabetes or sugar in urine. **If yes, a current Hgb A1C level from a medical professional is required. State name of insulin below.**
8.	☐	☐	Seizures, epilepsy, loss of consciousness or fainting spells
9.	☐	☐	Goiter or thyroid disorder
10.	☐	☐	Hernia, hemorrhoids or varicose veins
11.	☐	☐	Heart attack, angina or other heart disorders
12.	☐	☐	Stroke, paralysis or circulatory disorders
13.	☐	☐	Hypertension or high blood pressure. **If yes, a current blood pressure reading from a medical professional is required.**
14.	☐	☐	Liver or gallbladder disorder, jaundice or gallstones
15.	☐	☐	Kidney stone, kidney, bladder or prostate disorder
16.	☐	☐	Endometriosis, fibroids, prolapse, abnormal female bleeding, menstrual disorder or abnormal pap smear
17.	☐	☐	Infertility (male or female)
18.	☐	☐	Psychiatric, nervous or mental disorder, depression or attention deficit disorder
19.	☐	☐	Recurrent headaches or migraines
20.	☐	☐	Chemical dependency or alcoholism or been treated for the use of alcohol or drugs
21.	☐	☐	Ulcers, ulcerative colitis, Crohn's disease, stomach or intestinal disorders
22.	☐	☐	Back disorders, chronic low back pain or disk disorders
23.	☐	☐	Cataract, visual loss, ear infection or ear disorder
24.	☐	☐	Temporomandibular or Craniomandibular Joint Treatment (TMJ or CMJ)
25.	☐	☐	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
26.	☐	☐	**Any other condition, disorder, illness or disease** for which further diagnostic tests, consultation, observation, treatment, surgery or hospitalization has been recommended
27.	☐	☐	Have you or any of your Eligible Dependents been treated by a chiropractor in the last year? **If yes, state frequency of treatments and date of last treatment below.**
28.	☐	☐	Are you or any of your Eligible Dependents taking medicine prescribed by a physician? **If yes, list person(s) and medication(s) below.**
29.	☐	☐	Are you, your spouse or any of your dependent children pregnant? **(Indicate even if spouse/dependent children are not applying)**
30.	☐	☐	Have you or any of your Eligible Dependents had a vaginal or Cesarean Section delivery within the past six months? If yes, provide the date of postnatal visit for vaginal delivery or date of Cesarean Section delivery below.
31.	☐	☐	Are you or any of your Eligible Dependents currently a resident in a custodial center or nursing home?
32.	☐	☐	Has any person named in this application been ill, injured or consulted with a health care provider **for any other reason within the past five years**?

Explain "yes" answers to any of the above questions. Give complete details. Also indicate the patient's current physician. Use extra paper if necessary.

Question Number	Patient First Name	Diagnosis, Treatment or Reason for Medical Attention	Attending Physician Name and Address	Current Physician Name and Address	Date of Onset	Days in Hospital	Recovery Date	Workers' Comp. (Y/N)	No-Fault (Y/N)

6. SIGNATURE(S) *(This form must be signed and dated)*

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 cancelling 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 **Date Signed**

X _____
Spouse's Signature *(if to be insured)* **Date Signed**

X _____
Agent's Signature *(if applicable)* **Date Signed**

Agent Number & Name	
Amount Rec'd with App **$** _____ . ____	Voucher Number

WHITE ORIGINAL - BCBSND *YELLOW COPY - Agent* *WHITE COPY - Applicant*

If you have questions or require assistance when completing this application, please contact one of our offices listed below:

Home Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2227

Fargo District Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 282-1149

Grand Forks District Office
American Office Park
2810 19th Ave. S.
Grand Forks, ND 58201
Phone: (701) 795-5340

Dickinson Office
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

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

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

Member Services Toll-Free
(800) 342-4718

Visit us on the web
www.BCBSND.com

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 3, Coverage Information).

BLUE SAVER BENEFIT PLAN

I understand the Blue Saver Benefit Plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account. I also understand BCBSND does not provide tax, investment or legal advice. If I have questions about a Health Savings Account or the tax implications of the Blue Saver Benefit Plan, I should contact a qualified tax, investment or legal professional.

ELIGIBILITY REQUIREMENTS FOR PERSONAL CHOICE FOR STUDENTS

To be eligible for coverage under this Benefit Plan, the applicant must be a full-time student at an accredited post-secondary institution in North Dakota, or must be a resident of the state of North Dakota at an accredited post-secondary institution.

Coverage under this Benefit Plan terminates when the Subscriber ceases attending school and does not continue to pursue their education. If the Subscriber has not graduated or completed a defined course of study and has taken one academic term off (including the summer academic term) during an academic year, the Subscriber will remain eligible. However, the Subscriber under this Benefit Plan becomes ineligible for coverage if the Subscriber does not return to school on a fulltime basis for the first academic term immediately following a missed academic term (including the summer academic term.) Identical non-student coverage may be continued through the Personal Choice Benefit Plan.

ELIGIBILITY REQUIREMENTS FOR AFFORDABLUE

To be eligible for coverage under this Benefit Plan, the applicant must be age 19 or older and applying for single coverage.

LIMITATIONS AND EXCLUSIONS

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

Benefits are **not** available for any services, supplies or charges for the care or treatment received by me or any of my Eligible Dependents listed on this application for 365 days following the individual Member's effective date of coverage under the Benefit Plan for a condition, disease, illness or injury for which medical advice or treatment was received within the six-month period immediately preceding the individual Member's effective date of coverage under the Benefit Plan.

Benefits are **not** available for services received by me or any of my Eligible Dependents listed on this membership application for services received during the 365-day Waiting Period, beginning on the effective date of the individual Member's coverage for human organ and tissue transplants, tonsillectomies, adenoidectomies, typanostomies requiring the insertion of ventilating tubes, myringotomy without ventilating tubes, excision of cataracts, hysterectomies, sterilization procedures*, treatment of hernias, treatment of hemorrhoids, breast reduction surgery, surgical treatment of morbid obesity**, maternity delivery services (except for complications of pregnancy)***, postnatal care or the surgical treatment of gallbladder and the bile duct system.

The Waiting Period may be reduced by Qualifying Previous Coverage, if continuous until at least 63 days prior to the individual Member's effective date of coverage under the Benefit Plan.

Members under age 19 will not be subject to a Waiting Period.

* **No coverage is available for sterilization procedures under the Basic Plan or Basic Conversion.**

** **No coverage is available for the treatment of morbid obesity under Personal Choice, Personal Choice for Students, AffordaBlue, Standard Plan, Basic Plan or Basic Conversion.**

*** **No coverage is available for maternity services under Personal Choice, Personal Choice for Students or AffordaBlue. Benefits will be available for services provided to treat complications caused by pregnancy.**

**** **No coverage is available for all newborn care under AffordaBlue.**

No coverage is available for infertility services under Personal Choice, Personal Choice for Students, AffordaBlue, Standard Plan, Basic Plan or Basic Conversion.