NEBRASKA

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

EHA Health and Dental Enrollment Form

☐ New Application (Complete all sections except Section C. Complete Section H, if applicable.)

☐ Change (Complete all sections except Section B. Complete Section H, if applicable.)

Please print in black ink. If you need more space you can use a separate sheet of paper. Please include your name and social security number.

Section A. APPLICANT INFORMATION

Social Security Number	Name (Last) (First) (M.I.)	Date of Birth (Mo./Day/Year)	☐ M ☐ F

Address (Street, P.O. Box) (City) (State) (Zip+4 Code) (County)	Telephone Number ( )	☐ Single ☐ Married ☐ Divorced

School District Name	Group Number	Job Title	Date employed w/Group	No.of hours worked per week
Fort Calhoun Community Schools				

Are you, your spouse or your dependent(s) current or former Blue Cross and Blue Shield insureds or applicants? ☐ Yes ☐ No If Yes, please give name(s) & ID number(s).

Is spouse terminating other Blue Cross and Blue Shield coverage? ☐ Yes ☐ No If Yes, please give reason and effective date:

Section B. HEALTH AND DENTAL ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES

☐ HEALTH — reset health options

- ☐ One Person
- ☐ Employee/Spouse
- ☐ Employee/Children
- ☐ Family

- ☐ Standard PPO Option
- ☐ $1650 Deductible Option (if available for your School District)
- ☐ HSA-eligible High Deductible Plan Option (if available for your School District)

☐ DENTAL — reset dental options

- ☐ One Person
- ☐ Employee/Spouse
- ☐ Employee/Children
- ☐ Family

Section C. HEALTH AND DENTAL CHANGE ELECTION(S) FOR CURRENT MEMBERS (Complete Section D also to add Dependents)

reset change options

- ☐ Change to One Person Health
- ☐ Change to Employee/Spouse Health
- ☐ Change to Employee/Children Health
- ☐ Change to Family Health
- ☐ Change to One Person Dental
- ☐ Change to Employee/Spouse Dental
- ☐ Change to Employee/Children Dental
- ☐ Change to Family Dental

Change Reason: (◯) Divorce (◯) Spouse Deceased (◯) Marriage (◯) Other Date: _____

☐ Add Dependent(s): Date Dependent(s) joined your household: _____

☐ Other Health/Dental Changes: _____

Section D. PERSONAL DATA

List below spouse and other dependent(s) to be covered including eligible children under age 26.
LIST IN ORDER OF AGE - OLDEST FIRST.

Full Name (Last, First, M.I.)	Social Security Number	Date of Birth (Mo., Day, Year)	Sex M	Sex F	Relation to Employee

Name (Last)	(First)	(M.I.)	Social Security Number

Section E. PRIOR INSURANCE INFORMATION

Are YOU or DEPENDENT terminating (or losing) other health coverage?
If YES, the following information will help you avoid delays in claim payments:
PLEASE NOTE: There is a 12-month waiting period for pre-existing conditions decreased by previous creditable coverage.

1) List all the plans that insured you and your dependent(s) within the last 24 months:

Insurance Company	Policy Holder Name and Social Security Number	Relationship to Employee	DOB (MM/DD/YY)	Policy Number	Effective Date	Termination Date

2) Attach the "CERTIFICATE OF CREDITABLE COVERAGE" from the previous insurer.
If you haven't received this form, contact the insurance company and ask for one.

3) Give us the name(s) and telephone number(s) of the prior employer(s) who provided health coverage:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

4) Give us the reason for loss of other health coverage:

☐ I quit my job ☐ Death, divorce, or legal separation ☐ I/we voluntarily chose to drop other insurance
☐ Spouse quit his/her job ☐ I/we have reached the end of COBRA coverage ☐ Other: _____

Section F. CURRENT INSURANCE INFORMATION - Complete this section if you are keeping other insurance in addition to this Plan.

Insurance Company	Insured's Name	Names of Covered Persons	Effective Date	Address and Telephone of Insurance Company

MEDICARE SECONDARY PAYOR INFORMATION

Are you, your spouse, or dependent(s) enrolled in Medicare? ☐ Yes ☐ No If the answer is "yes," please fill in requested information below:

If Medicare: Name of Beneficiary _____

Medicare HIC #: _____

Part A effective date: _____

Part B effective date: _____

Reason for entitlement (check all applicable boxes): ☐ Age ☐ Disability ☐ End stage renal disease

Section G.

I represent that my answers and statements in this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation in this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS NOTICE

This Plan imposes a waiting period for pre-existing conditions. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in an eligibility waiting period for coverage, the six-month waiting period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to covered persons under 19.

Name (Last)	(First)	(M.I.)	Social Security Number

Section G. (continued)

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the waiting period for pre-existing conditions and creditable coverage should be directed to our Member Services Department at (402) 390-1820 or toll-free 1-800-642-8980.

SPECIAL ENROLLMENT NOTICE

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information contact our Member Services Department at (402) 390-1820 or toll-free 1-800-642-8980.

Signature of Applicant: _____ Date: _____

Section H. DECLINATION OF COVERAGE. Complete only if you elect not to participate in the group insurance offered.

Social Security Number _____ Name _____

School District Name _____ Group Number _____

The group health/dental program has been offered to me and after seriously considering its benefits, I have decided:

- ☐ not to enroll myself in the health/dental plan.
- ☐ not to enroll myself and my dependents in the health/dental plan.
- ☐ not to enroll my dependents in the health/dental plan.

Coverage in the health/dental plan is declined because:

- ☐ I am enrolled and/or ☐ My dependents are enrolled, under my spouse's health coverage.
  My spouse is employed by (name of firm) _____
- ☐ I am enrolled and/or ☐ My dependents are enrolled, under a COBRA continuation or state continuation coverage.
- ☐ I have and/or ☐ My dependents have, individual coverage through ☐ Medicare ☐ Medicaid ☐ SCHIP ☐ another insurance company
- ☐ Other reason(s) _____

If you decline health/dental enrollment for yourself and your dependents, a request for enrollment at a later date may not be allowed, or may be subject to late enrollment restrictions (if requested other than during a special enrollment period). See "Notice" above.

Signature of Applicant: _____ Date: _____