BlueCross BlueShield Minnesota

Health Insurance Enrollment Form

Effective Date: ______________________________

A. GROUP EMPLOYEE ENROLLMENT FORM

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone

Employee's Home address	Street	City	State	Zip code	Work phone

Employee's Email address

B. PLAN CHOICE

☐ $1,200 Single ☐ $2,400 Family ☐ $2,250 Single ☐ $4,500 Family ☐ $3,000 Single ☐ $6,000 Family ☐ Other _______________

C. LIST ALL INDIVIDUALS TO BE ADDED– COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation	Last name *List address if different	First name	M.I	Effective Date	Sex M/F	Marital status	Social Security #	Birth Date (Mo. Day Yr.)
Self								
Spouse								
Child								
Child								
Child								

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X

Signature of employee

Month Day Year

Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	**Requested Effective Date:**

Indicate the reason employee is enrolling for coverage:

1 New employee
1 Rehire (length of layoff) ____________
1 Return from leave of absence (length of absence) ______________________________
1 New group
1 Previously waived coverage
1 Change from part-time to full-time

1 Certificate of coverage termination
1 Other ______________________________

Date of event: ______________________________

I certify the above information to be true and correct.

Signature____Date ______________________________

Employer name	Telephone number	Fax number