U of M Student Special Enrollment Application for Individual/Family Plan

☑️ Please Complete Steps 1-6.
If you are an insurance agent/producer, please complete Steps 1-7.

Step 1) Tell us about yourself.
Step 2) Tell us about your household.
Step 3) Find your county and choose your plan. Before selecting a plan, make sure your provider is in-network for that plan. Not every provider is in every network, and not every plan is available statewide.
Step 4) Tell us if you have other health insurance.
Step 5) Sign, authorize, and date your Application.
Step 6) Send your completed Application (all pages) and payment to Blue Plus.
Step 7) If you are an insurance agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.

❓ Contact the Student Health Benefits Office at 612-624-0627 or 1-800-232-9017 or go online: shb.umn.edu.
Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.
Attention: If you want free help translating this information, call the above number. Atención: Si desea ayuda gratuita para traducir esta información, llame al número que aparece arriba.

❓ General Information

- Only use this form if you are requesting to coordinate the effective date of your new plan with the termination date of your U of M student coverage plan.
- If you are requesting an effective date other than to coordinate with the termination date of your U of M student coverage plan, please visit www.bluecrossmn.com for other plan options available to you.
- You must be a resident of Minnesota. You may obtain our Residency Policy at www.bluecrossmn.com/residencypolicy or toll free at 1-800-262-0823 and one of our representatives will be happy to assist you.
- Individuals (whether you or any dependent) enrolled in or receiving benefits under Medicare Part A and/or Part B are not eligible to enroll in an individual commercial plan. If you enroll in a Blue Plus individual commercial plan, you must immediately notify Blue Plus if you (or any dependent) enroll in or obtain health insurance benefits under a Medicare program after submitting this Application or at any time during your period of coverage in the Blue Plus plan.
- If eligible, coverage will be provided under an individual contract. Blue Plus does not issue individual coverage through any arrangement with an employer.
- Please note, Blue Plus may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include commercial entities, healthcare providers and suppliers, and any person or entity (which may include a religious institution or other not-for-profit organization) that does not meet the criteria set forth by the Minnesota Departments of Commerce and Health in Administrative Bulletin 2016-3 ("Third-Party Payments of Premiums or Cost- sharing Expenses"). "Ineligible third parties" also include any other person or entity from which Blue Plus is not required by law to accept third-party premium and/or cost-sharing payments. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic fund transfer, etc. If you have questions about this third party payment policy or whether Blue Plus will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at 1-800-382-2000 before you complete this application.
General Information - continued

- Pediatric dental coverage is an essential health benefit available for purchase through a separate contract. For additional information on available pediatric dental plans, please visit www.mnsure.org. Pediatric dental benefit coverage is provided by an independent company.
- A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmnh.com or available free of charge when requested by calling one (1) of the phone numbers listed on page 1.
- Please complete this entire application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed. This may affect the date your coverage starts. Sign and date this Application. This Application must be received at the home office of Blue Plus within 15 days of your signature. Incomplete Applications are null and void after 30 days.

STEP 1 - Tell Us About Yourself

Existing Blue Cross or Blue Plus ID# _____________________________________________________________

I am a new applicant:

☐ Applying for coverage for myself only ____________________ ☐ Applying for coverage for myself and my dependents
☐ Applying for coverage on behalf of my child(ren). If you are applying on behalf of a child under the age of 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child.

*In order to be added at this time, you and/or your dependent(s) must have been enrolled on the University Student Health Benefit Plan (SHBP).

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety*. PLEASE PRINT CLEARLY.

*Social Security Numbers (SSN) for you and your dependents are requested for benefit administration and reporting to the Internal Revenue Service (IRS) so you may demonstrate having minimum essential coverage and avoid having to pay a tax penalty. Please include SSN with your Application, however, it's not required.

Name
First Name, Middle Name, Last Name & Suffix

Social Security Number (If no SSN, write N/A)  Sex ☐ Male ☐ Female  Date of Birth (mm/dd/yyyy)  Apartment Number

Permanent Home Address (No P.O. Box #)  City State Zip Code County

☐ Correspondence address (If different from home address)  Apartment Number

City State Zip Code County

☐ Billing address (If different from permanent home and mailing address)  Apartment Number

City State Zip Code County

Email address

Home phone number (non-mobile)  Work phone number  Cell phone number

1. ☐ Yes ☐ No I am a permanent resident of Minnesota since: ________________________________ (mm/dd/yyyy)

2. Check this box to confirm that no enrollee will receive any premium or cost-sharing assistance for this policy, directly or indirectly, from any ineligible third party described on page 1 above. ☐ I confirm.

3. Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No

If Yes, when was the last time you used tobacco regularly? ________________________________ (mm/dd/yyyy)

GO TO STEP 2

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**STEP 2 - Tell Us About Your Household**

Tell us about everyone who is applying for coverage.

<table>
<thead>
<tr>
<th>Full Name (First, MI, Last)</th>
<th>Relationship to Applicant</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Social Security Number</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
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<tr>
<td><strong>Does this person live at the same address as you?</strong></td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>If No, list address:</td>
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<tr>
<td>Applicants 18 years of age or older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?</td>
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<td><strong>Does this person live at the same address as you?</strong></td>
<td>☐ Yes ☐ No</td>
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<td><strong>Does this person live at the same address as you?</strong></td>
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<td><strong>Does this person live at the same address as you?</strong></td>
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<td>6</td>
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</tbody>
</table>

☐ Additional dependent(s) on attached page

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**STEP 3 - Choose Your Plan**

Find your county and choose your plan. Before selecting a plan, make sure your provider is in-network for that plan. Not every provider is in every network, and not every plan is available statewide.

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

For plans with more than one person (family plan), no one member will exceed the single deductible amount listed below. Also, eligible costs incurred by all covered family members count toward satisfying the family deductible.

I am/we are applying for coverage under:

<table>
<thead>
<tr>
<th>BlueConnect&lt;sup&gt;SM&lt;/sup&gt; (Blue Plus) - Single/Family Plans</th>
<th>BluePrint&lt;sup&gt;SM&lt;/sup&gt; (Blue Plus) - Single/Family Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Available for residents in the following counties:</strong> Becker, Beltrami, Big Stone, Cass, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac Qui Parle, Lincoln, Lyon, Mahnomen, Marshall, Meeker, Murray, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rock, Roseau, Stevens, Swift, Todd, Traverse, Wadena, Wilkin, Yellow Medicine</td>
<td><strong>Available for residents in the following counties:</strong> Anoka, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, McLeod, Nicollet, Ramsey, Scott, Sherburne, Sibley, Washington, Wright</td>
</tr>
<tr>
<td><strong>Network:</strong> Sanford Health</td>
<td><strong>Network:</strong> Allina Health</td>
</tr>
<tr>
<td>80% Plans</td>
<td>80% Plans</td>
</tr>
<tr>
<td>□ $1,200/$3,600 Plan 251</td>
<td>□ $1,200/$3,600 Plan 254</td>
</tr>
<tr>
<td>□ $2,400/$7,200 Plan 250</td>
<td>□ $2,400/$7,200 Plan 253</td>
</tr>
<tr>
<td>100% Plan</td>
<td>100% Plan</td>
</tr>
<tr>
<td>□ HSA $6,550/$13,100 Plan 257</td>
<td>□ HSA $6,550/$13,100 Plan 258</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Plus with St Luke’s&lt;sup&gt;SM&lt;/sup&gt; (Blue Plus) - Single/Family Plans</th>
<th>Blue Plus with Mayo&lt;sup&gt;SM&lt;/sup&gt; (Blue Plus) - Single/Family Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Available for residents in the following counties:</strong> Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, Lake of the Woods, Pine, Saint Louis</td>
<td><strong>Available for residents in the following counties:</strong> Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan, Winona</td>
</tr>
<tr>
<td><strong>Network:</strong> St. Luke’s</td>
<td><strong>Network:</strong> Mayo Clinic</td>
</tr>
<tr>
<td>80% Plan</td>
<td>80% Plan</td>
</tr>
<tr>
<td>□ $1,200/$3,600 Plan 282</td>
<td>□ $1,200/$3,600 Plan 272</td>
</tr>
<tr>
<td>85% Plan</td>
<td>85% Plan</td>
</tr>
<tr>
<td>□ HSA $2,750/$5,500 Plan 281</td>
<td>□ HSA $2,750/$5,500 Plan 271</td>
</tr>
<tr>
<td>100% Plan</td>
<td>100% Plan</td>
</tr>
<tr>
<td>□ HSA $6,550/$13,100 Plan 280</td>
<td>□ HSA $6,550/$13,100 Plan 270</td>
</tr>
</tbody>
</table>

The deductible, copay and out-of-pocket maximum amounts are subject to annual adjustments.
STEP 4 - Tell Us About Other Health Insurance Information

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? □ Yes □ No

2. Will you or any dependent(s) named on this Application be enrolled in either Medicare Part A or Medicare Part B or both? □ Yes □ No

3. Is this coverage for which you are applying Intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Blue Cross or Blue Plus policy. If you have a current individual/family policy, your current policy will generally be replaced as of the effective date of your new plan Unless your current coverage is through an employer. □ Yes □ No

If Yes, to any question above, complete question 4. If No, skip question 4 and go to the next section.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

   Name of Insurance Carrier or Governmental Plan: ___________________________ Group Number: ______________

   Name of Policy Holder: ___________________________ Effective Date: ______________

   Policy Number: ___________________________ Relationship to Applicant: ______________

   Policy Holder's Date of Birth: ___________________________ Policy Holder's Employment Status: ______________

Effective Date of Coverage

Enrollment form must be received within 60 days from the termination date of the U of M student coverage. The effective date will be the day after the termination date of your U of M student coverage as assigned by SHBP Boynton Health Services.

Termination date of SHBP coverage: August 20, 2017

Office of Student Health Benefits signature: Katherine P. Sigwalt

Your coverage may not take effect until we receive your first premium payment. Failure to pay by the due date on your first invoice could delay your effective date.

REMITTANCE SLIP

Please complete the Remittance Slip to pay your first month's premium. If you do not complete the Remittance Slip, you will be billed separately for your first month's premium. Note: If you are a current Blue Cross or Blue Plus member signed up to use Pay It Easy, your first month's premium under your new plan may not be automatically debited from your account, and you may need to complete and submit a new Pay It Easy form for your recurring payment.

Policyholder Name (First, Middle, Last): ___________________________ Zip Code: ______________ Social Security Number: ______________

Monthly Premium for the plan you selected, based on applicants Indicated on this Application: ______________

Payment Enclosed: $ ______________ Plan Number (see page 4): ______________

If you plan to fax/email your Application, mail in this page with your first month's payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 9.

Applicant's Last Name ___________________________ First Name ___________________________
STEP 5 - Sign, Authorize and Date Application

My/our signature on this Application indicates that I/we have read and fully understand the following statements when applying for health coverage through Blue Cross and Blue Shield of Minnesota and/or Blue Plus (Blue Plus); I understand and agree that coverage, if approved, will begin as specified on page 7. I authorize Blue Plus either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Plus uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Plus receives my check and I will not receive my check back from my financial institution.

I understand that coverage will be provided under an individual contract. I understand that Blue Plus does not issue individual coverage through any arrangement with an employer. Blue Plus is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

For purposes of obtaining information in connection with this Application, reinstatement, or change in policy benefits, this release is valid as long as I am continually covered with Blue Plus. I am entitled to receive a copy of any release I sign. I agree if I am enrolling in a product that features certain designated providers, Blue Plus may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

Blue Plus primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the applicant and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the application, even if I and/or dependent(s) listed on this Application currently have coverage or had prior coverage with Blue Plus. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Plus will rescind my contract and coverage, and no claims will be paid. I further attest that I was not encouraged or advised to apply for this coverage in connection with any offer by an "ineligible third party" (described on page 1) to directly or indirectly pay all or some of my premiums or cost-sharing.

I understand and agree that payment of a claim does not preclude the right of Blue Plus to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid. I understand that this plan does not include coverage for the pediatric dental essential health benefit and that Blue Plus has made me aware of pediatric dental coverage available for purchase through a separate contract.

I agree to notify Blue Plus immediately of any change in my (or my dependent(s)) enrollment information contained in this Application or otherwise provided. Failure to notify Blue Plus of any change in the information contained in this Application or otherwise provided may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependent(s) enrolling for coverage. I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Plus will act in reliance upon the information I have provided on this Application which materially affects enrollment eligibility and may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

I understand that this Agreement renews on an annual basis. I acknowledge that if my first payment is not made with this Application, premium payment is required by the due date printed on my first invoice. I understand that failing to pay before this due date will result in my application being voided. I understand that payments in advance of the monthly amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received. I acknowledge that if my on-going monthly premium payments are not received within the plan grace period, my plan will be terminated. I understand that nothing in this Application creates a contract, and that, if this Application is approved, coverage will not take effect until I have made my first premium payment. I understand that the date I pay my first premium may impact my desired effective date.

If this Application is completed as an electronic or online application, both parties agree to conduct this transaction electronically.

Applicant’s Signature ___________________________________________ Date ______________

Spouse/Domestic Partner/Parent’s Signature ____________________________ Date ______________

This Application Is Valid Only When Completed and Signed By The Applicant/Parent (if applying for a child under age 18).
STEP 6 - Send Your Completed Application and Payment to Blue Plus

Send in your completed application and payment to Blue Plus by one of the following methods.

**U.S. Mail:**
Include your completed, signed Application along with your first premium payment to:
Blue Plus
P.O. Box 64024
St. Paul, MN 55164

**Fax or email:**
Fax your completed, signed Application to 651-662-6439 or email to enrollment.forms@bluecrossmn.com
-- and -- mail your first premium payment with completed remittance slip to:
Blue Plus
P.O. Box 64024
St. Paul, MN 55164

**Drop Your Application and Payment Off In Person At Your Local Blue Cross and Blue Shield of Minnesota and Blue Plus Retail Center:**
For locations, please visit www.bluecrossmn.com or call 1-800-382-2000.
You may also visit bluecrossmn.com/centers to make an appointment near you.

**Please Note:** This Agreement renews on an annual basis. You can pay your premium monthly in advance to Blue Plus. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis during the calendar year. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Please note. Processing of your Application may be delayed if this Application is NOT completed in its entirety. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to your situation, please mark as 'N/A'.

**Notice of Nondiscrimination Practices** Effective July 18, 2016
Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender. Blue Cross provides resources to access information in alternative formats and languages:
- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at (651) 662-8000 or by using the telephone number on the back of your member identification card. TTY: 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator by mailing it to:
Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
PO Box 64560, M495,
Eagan, MN 55122-1154

Grievance forms are available by contacting us at the numbers listed above. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:
https://ecrportal.hhs.gov/ocr/portal/lobby.jsf, by phone at:
1-800-368-1019 or 800-537-7697 (TDD), or by mail at:
U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F
HHH Building
Washington, DC 20201
PRODUCER'S CERTIFICATE

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-800-262-0821.

If this section is not fully completed, we will not pay a commission.

Blue Cross Blue Shield Agency No.  N E F  Producer No.  9 8 7 8

A PRODUCER must complete this section to act on the applicant's behalf.

I certify that I have met the requirements listed in Minnesota Statute 60K.46 subdivision 4 regarding suitability, as well as those requirements set forth in the Agent Code of Conduct and within the Blue Cross and Blue Shield of Minnesota and Blue Plus contractual agreement. I further understand, no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy or waive Blue Cross and Blue Shield of Minnesota's and/or Blue Plus' rights or requirements.

It is your responsibility as a producer to retain a signed copy of this Application for your records.

Agency Name  Hays Companies
Producer's Name  Seifert Thomas
Producer's Signature
Business Phone  62 3 7 3-9 8 7 8

Blue Cross Blue Shield of Minnesota and Blue Plus
3535 Blue Cross Road
Eagan, MN 55122

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

INTERNAL USE ONLY

Blue Cross Blue Shield Agency No.  N E F  Producer No.  9 8 7 8

X20936R01 (09/16)
Este aviso tiene información importante sobre su solicitud de cobertura del plan de salud. Busque fechas clave en este aviso. Es posible que deba tomar medidas antes de ciertos plazos para mantener su cobertura o recibir ayuda con los costos. Si usted, o alguien a quien esté ayudando, tiene preguntas sobre este aviso o sobre la cobertura del plan de salud, puede recibir información y ayuda en su idioma sin costo. Para comunicarse con un intérprete, llame al número gratuito 1-855-903-2583.

Tsab ntawv ceeb toom no muaj cov lus tseem ceeb hais txog koi daim ntawv thov los yog qhov kev pab them rau koi daim phiaj npaj kho mob. Saib cov hnb tseem ceeb nyob hauv daim ntawv ceeb toom no. Tej zaum koi yuav tau ua qee yam kom tiav ua ntej qee cov hnb uas teev rau hauv no kom thiaj tsis poob qhov kev pab them los yog kom tau txais kev pab them cov nqi kho mob. Yog hais tias koi, los yog lwm tus uas koi pab, muaj lus nug txog tsab ntawv ceeb toom no los yog qhov kev pab them rau daim phiaj npaj kho mob, koi muaj cai tau txais kev pab thiab ntaub ntawv ua koi hom lus yam tsis tau them nyiaj dab tsi. Yog xav tham nrog ib tus neeg pab txhais lus, hu rau tus xov tooj 1-800-793-6931 (hu dawb).

Ogeyisikan wuxuu wataa macluumaad muhiim ah oo ku saabsan caynsanaanta qorshahaaga caafimaad. U fiirso taariikaha ku yaal ogeyisikan. Waxaa lagu yaabaa inaad u baahto facil ka qaad taariikkaha kama dambaysa ah si aad u sii haysto caynsanaantaada ama aad ugu hesho caawimo kharashyada. Haddii adiga, ama qof aad caawinayo, u ka qaboo su’aalo arrimaha ku saabsan ogeyisikan ama caynsanaanta qorshaha caafimaadka, waxaad ku heli kartaa caawimo iyo macluumaad luqaddaada iyada oo aan kharashkaa bixin. Si aad ugu hadsho turjumaan, soo wac 1-866-251-1576 (Iac la’aan).


Thong bao nay co thong tin quan trong ve don dang ky hoac pham vi bao trach theo chuong trinh suc khoe cua quy vi. Tim nhung ngay chinh trong thong bao nay. Quy vi co the can h ancient truc mot so thoi han de duy tri pham vi bao trach hoac duoc giup do co tinh phi. Neu quy vi, hoac nguoi quy vi dang giup do, co thac mac ve thong bao nay hoac pham vi bao trach theo chuong trinh suc khoe cua quy vi, quy vi co the nhan giup do va thong tin bang ngon ngu co minh men phi. De noi chuyen voi mot thong dich vien, xin goi so 1-855-315-4015 (miem phi).

本通知包含與您申請或健康計劃承保有關的重要資訊。請注意本通知中的重要日期。您可能需要在特定期限之前採取行動才能維持承保或取得費用補助。如果您本人或您協助的對象對本通知或健康計劃承保有疑問，您可免費以您的語言取得協助和資訊。如欲與口譯員交談，請致電1-855-315-4017（免費電話）。

image_0004_NDR_Notice_Portrait (08/16)
В этом уведомлении содержится важная информация о Вашей заявке на включение в план или страховое покрытие, предоставляемом планом медицинского страхования. Обратите внимание на даты, приведенные в этом уведомлении. Для того чтобы сохранить страховой или получить помощь в связи с какими-либо выплатами, Вам, возможно, потребуется к определенному сроку предпринять какие-то действия. Если у Вас или у кого-то, кто Вам помогает, появятся вопросы по поводу этого уведомления или предоставляемого планом страхового покрытия, Вы можете бесплатно получить помощь и информацию на Вашем родном языке. Чтобы связаться с переводчиком, позвоните по телефону 1-855-315-4028 (звонки бесплатные).

**дефект на странице:**

**Телефон:** 1-866-356-2423 (воспрепятствуйте).

본 통지서에는 귀하의 보험 가입이나 의료 보험 적용 범위에 대한 중요한 정보가 담겨 있습니다. 본 통지서에 나와 있는 중요한 날짜를 확인해 보십시오. 귀하께서는 특정 마감 기한에 따라 조치를 취해야만 계속 보험 적용을 받거나 비용 지원을 받으실 수 있습니다. 귀하 본인이나 귀하가 도와주고 있는 사람이 본 통지서나 의료 보험 적용 범위에 대한 질문이 있는 경우, 본인 비용 부담 없이 모국어로 지원 및 정보를 받으실 수 있습니다. 통역사와 통화를 하시려면, 1-855-904-2583 번 (수신자 부담)으로 연락하시기 바랍니다.

Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw ng planong pangkalusugan. Maghanap ng mahahalagang petsa sa paunawang ito. Maaaring kailanganin mong gumawa ng aksyon sa pamamagitan ng ilang mga itinakdang panahon upang mapanatili ang iyong saklaw o makatanggap ng tulong para sa mga gastos. Kung ikaw, o ang isang tao na tinutulungan mo, ay may mga katanungan tungkol sa paunawang ito o saklaw ng planong pangkalusugan, makatanggap ka ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang taga-interpret, tumawag sa 1-866-537-7720 (walang bayad ang toll).

Díi éi nits’ís baa áháyá binaaltsoos dóó bee nik’i adees’t’íí aláahgo binahjí’ ééhózinígi át’é. Yoołkáád dábiká’ií baa ákoníniz dooleeí. Łahda t’áadoó áají’ iilkááhi’ éi díí naaltsoosshazhdiíí’ [ihn díí shá bik’é aálaadoo janízingo]. Ni éi dódagoó t’áá háída biká’anilyeydigi díí naaltsoos dóó bik’é azlähígi bąq̥ na’idikid neholólógo éi t’ázíjik’ é t’áá nízaad k’éjhi’ bee niihoóonih dóó nik’áadooloogó éi át’é. Ata’ halne’é ló bíchí’ hadeesdzhií nínízingo éi 1-855-902-2583jí’ t’áá jíjík’ é béésh bee hodílñih.