BlueCross BlueShield of Montana

Applicant Name: _____

Social Security Number: _____

Member ID (if applies): _____

Internal Use Only

Sign Up for a **2027 Health Plan** for You and Your Family.

You can sign up online at **BluePlanCompareMT.com**. If you choose to apply with this form, visit **bcbsmt.com/how-to-apply** for step-by-step instructions and additional information. Whether online or using this form, if you are working with an independent, authorized Blue Cross and Blue Shield of Montana agent, they must complete the agent section.

Help us process your Application more quickly.

If applying during Open Enrollment, leave page 3 blank except for name and SSN. Complete page 3 **only** if you have a qualifying life event and are applying outside annual Open Enrollment. Check **bcbsmt.com/sep** to see if you qualify for a Special Enrollment Period before filling out this Application. To receive language or communication assistance free of charge, call **1-855-710-6984**.

BEFORE SUBMITTING THIS FORM, PLEASE CONFIRM:

- Name and SSN are at the top of **all 12 pages**.
- **All questions** that apply to you and any dependents have been answered.
- All answers are in black ink. (Pencil will not be accepted.)
- Any answer you changed is clearly marked and initialed. (Do not use correction fluid or tape.)
- The Application includes the Primary Applicant and **all current and new** dependents.
  - If you need more dependent sections, visit **bcbsmt.com/how-to-apply** to download an Application overflow page.
  - **Proof of ineligibility for Medicare is required** for any Applicant or dependent age 65 or older.
- Payment details on page 8 are complete, for first payment and monthly payments.
- The Application is signed everywhere a signature is required (pages 7, 8, 10 and 12).
  - If the primary applicant is a minor child, or an individual legally unable to sign, all signatures were made by their parent, legal guardian or personal representative.
- Submit all 12 pages, even pages you don't use. Fax to **1-800-279-7419**.

What do you want to do?

Applicant Name: _____

SSN: _____

☐ Become a **NEW** member.

☐ **CHANGE** my 2027 health plan.

☐ **ADD** a dependent to my current health plan.
(You may add a newborn within 60 days of birth by calling 1-855-258-8471. No Application is needed.)

How we will contact you.

If you want to get information from us electronically, we must have your email address. **By listing an email address, you agree we may send your policy information electronically**, such as policy kits, explanation of benefits and claim letters. This electronic delivery will continue through any policy renewals or changes.

You can change to paper delivery at any time with no penalty. To make or change your choices once you are a member, you may:

- Update your preferences and contact information at **mybam.bcbsmt.com**.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge or Safari.

Will you use a reimbursement arrangement?

Are any of the applicants purchasing this plan using an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)? **If yes, please complete the below.**	☐ Y ☐ N
Select one: ☐ **ICHRA** ☐ **QSEHRA**	
Effective Date of the ICHRA or QSEHRA	**Monthly Contribution Amount**
Employer Name	

Signing up outside Open Enrollment?

Applicant Name: _____

SSN: _____

If you are signing up during Open Enrollment, enter your name and SSN above, then skip to the next page. You can also apply online at BluePlanCompareMT.com.

DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period. An SEP is a chance to sign up outside Open Enrollment.

- **You must apply within 60 days before or after the qualifying life event, depending on which event you claim.**
- Check more than one event if more than one happened to you.
- **When required, BCBSMT will review valid proof of a qualifying life event before processing your Application.**
- Once your plan has been issued, your SEP cannot be re-used to apply for a different plan.

See **bcbsmt.com/sep** or contact your independent, authorized agent for more information.

☐ **1.** My dependent(s) and/or I lost Minimum Essential Coverage as of this date because, for example: • Of reasons beyond my control (not including reasons like failure to pay my full premium or any disregard on my part for the plan's rules).[1] • I turned age 26.[1,2] • The plan holder became eligible for Medicare.[1] • The plan holder died.[3] • I lost my job, I lost hours, my employer stopped making payments, or my COBRA benefits ended.[1] • Someone on my plan was legally separated or divorced.[1] • My plan stopped covering people in my situation.[1]	Date of **Event**
☐ **2.** I got married on this date.[3]	Date of **Event**
☐ **3.** I had a baby, adopted a child, had a child placed with me for adoption, took in a foster child, or was ordered to cover a dependent through a court order as of this date.[3]	Date of **Event**
☐ **4.** There was a mistake when I signed up for my last health plan, or I have shown proof that my previous health plan or issuer broke its contract with me as of this date.[3]	Date of **Event**
☐ **5.** Someone on my plan had a change in income and lost advance payment of premium tax credit, cost-sharing reductions, or Medicaid, or my last non-Marketplace plan broke government rules as of this date.[1]	Date of **Event**
☐ **6.** I got new health plan options when I moved on this date.[1]	Date of **Event**
☐ **7.** My current plan ends on a date other than December 31, which is this date.[1]	Date of **Event**
☐ **8.** My employer offered to help with the cost of coverage either through an ICHRA or a QSEHRA. ☐ **a.** My employer is newly offering as of this date.[1] ☐ **b.** I am a new employee and my employer is offering as of this date.[1]	Date of **Event** **a.** _____ **b.** _____
☐ **9.** An allowed reason not on this list, on this date. Contact your agent or call **1-844-525-6188** for help.[1]	Date of **Event**

[1] You must apply within 60 days before or after the qualifying life event.
[2] A dependent covered under a parent's Marketplace plan has until December 31 of the year they reached age 26 to apply.
[3] You must apply within 60 days after the qualifying life event.

Tell us about you.

Applicant Name: _____

SSN: _____

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

PRIMARY APPLICANT (Who should be listed first on the health plan?)

First Name	Middle Initial	Last Name

Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N If YES, what language? _____

Do you prefer to read or write a language other than English? ☐Y ☐N If YES, what language? _____

Within the past six months, have you used tobacco?[1] 4 or more times per week on average, excluding religious or ceremonial uses ☐Y ☐N If YES, when did you last use tobacco? _____

Home Address	City	State	ZIP	County

Mailing Address (if different than home address)	City	State	ZIP

What is the best phone number to reach you?[2]

_____ ☐ Mobile ☐ Landline

By providing your mobile phone number on this Application, you agree to receive automated, informational text messages from BCBSMT, including from third-party vendors or providers directly contracted by BCBSMT, to answer questions and provide additional information about health plan products, benefits and programs. You may also set your preferences at **mybam.bcbsmt.com**. Standard mobile phone and/or text message charges may apply from your wireless provider. Messages will be recurring. Frequency will vary. Consent is not a condition of purchase or enrollment.

Email Address[2,3]

Primary Care Provider (FOR POS ONLY)	10-character PCP ID (FOR POS ONLY)

See **FindADoctorMT.com** to find a PCP. If you do not list a PCP above, BCBSMT will assign you a PCP based on your plan service area. PCP assignment may delay arrival of your member ID card. You may be responsible for the cost of care for a PCP that is not on your member ID card or for care from a provider not referred by your PCP. See note about PCPs and OB-GYNs on page 6.

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following? (check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

OPTIONAL: Are you or do you identify as any of the following? (check all that apply)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

[1] Age 21 and older for tobacco use.
[2] Age 18 and older for mail, phone and email.
[3] You **must** provide your email address if you want to get information electronically or if you want to pay with electronic funds transfer.

Tell us about you.

Applicant Name: _____

SSN: _____

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

If you need more dependent sections, please download and complete the Application overflow page. See bcbsmt.com/how-to-apply.

SPOUSE OR DEPENDENT CHILD[1] (Who else do you want your plan to cover?)

First Name	Middle Initial	Last Name

Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses

☐Y ☐N If YES, when did you last use tobacco? _____

Mailing Address[3]	City	State	ZIP

What is the best phone number to reach you?[3]

_____ ☐ Mobile ☐ Landline

By providing your mobile phone number on this Application, you agree to receive automated, informational text messages from BCBSMT, including from third-party vendors or providers directly contracted by BCBSMT, to answer questions and provide additional information about health plan products, benefits and programs. You may also set your preferences at **mybam.bcbsmt.com**. Standard mobile phone and/or text message charges may apply from your wireless provider. Messages will be recurring. Frequency will vary. Consent is not a condition of purchase or enrollment.

Email Address[3,4]

Primary Care Provider (FOR POS ONLY)	10-character PCP ID (FOR POS ONLY)

See **FindADoctorMT.com** to find a PCP. If you do not list a PCP above, BCBSMT will assign you a PCP based on your plan service area. PCP assignment may delay arrival of your member ID card. You may be responsible for the cost of care for a PCP that is not on your member ID card or for care from a provider not referred by your PCP. See note about PCPs and OB-GYNs on page 6.

If a dependent (other than spouse) is age 26 or older, does dependent have a medical disability? ☐Y ☐N
If YES, a Disabled Dependent Authorization Form is required. You can find the form at **bcbsmt.com/how-to-apply**.

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following? (check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

OPTIONAL: Are you or do you identify as any of the following? (check all that apply)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

[1] Non-spouse dependents can be up to age 26, unless medically disabled and continuing coverage with BCBSMT.
[2] Age 21 and older for tobacco use.
[3] Age 18 and older for mail, phone and email (if different from the Primary Applicant).
[4] You **must** provide your email address if you want to get information electronically.

Choose your health plan.

Applicant Name: _____

SSN: _____

Your coverage will start on the 1st of the month, unless otherwise required by law. Your Application must be received by BCBSMT within the defined enrollment period to be accepted.

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
☐ **Blue Focus Bronze POS℠ - Balance HSA**	$11,750
☐ **Blue Focus Bronze POS℠ - Champion HSA**	$5,000
☐ **Blue Focus Bronze POS℠ - Standard HSA**	$7,500
☐ **Blue Focus Bronze POS℠ - Signature HSA**	$5,200
☐ **Blue Focus Silver POS℠ - Standard**	$6,400
☐ **Blue Focus Silver POS℠ - Signature**	$3,000
☐ **Blue Focus Gold POS℠ - Champion**	$1,200
☐ **Blue Focus Gold POS℠ - Standard**	$2,500
☐ **Blue Focus Gold POS℠ - Secure**	$1,800

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
☐ **Blue Preferred Bronze PPO℠ - Standard HSA**	$7,500
☐ **Blue Preferred Bronze PPO℠ - Signature 1 HSA**	$5,200
☐ **Blue Preferred Bronze PPO℠ - Signature 2**	$9,950
☐ **Blue Preferred Bronze PPO℠ Support HSA**	$8,000
☐ **Blue Preferred Silver PPO℠ - Balance**	$7,000
☐ **Blue Preferred Silver PPO℠ - Champion**	$3,100
☐ **Blue Preferred Silver PPO℠ - Signature**	$2,500
☐ **Blue Preferred Silver PPO℠ - Standard**	$6,400
☐ **Blue Preferred Gold PPO℠ - Balance**	$2,500
☐ **Blue Preferred Gold PPO℠ - Secure**	$1,800
☐ **Blue Preferred Gold PPO℠ - Standard**	$2,500

"CATASTROPHIC" PLAN OPTIONS BELOW

Here's what that means.

These plans cover essential health benefits, but generally only after you pay the high deductible or the out-of-pocket maximum amount. **You qualify for these plans only if:**

1) you are under age 30 before the plan year begins, **or**
2) you have a waiver from the Health Insurance Marketplace®.
Your Exemption Certificate Number is required to process your form. **Exemption Certificate Number:** _____

☐ **Blue Focus Security POS℠ - HSA**	$12,000
☐ **Blue Preferred Security PPO℠ - HSA**	$12,000

OB-GYN ACCESS

You may get OB-GYN services from your Primary Care Provider (PCP) or an OB-GYN.

- If choosing a POS plan, you may select an OB-GYN as your PCP. Include details about your selected OB-GYN where we ask you to identify your PCP.
- If your PCP is part of a Limited Provider Network (LPN), the plan will cover your OB-GYN visits only if your OB-GYN is part of the same LPN.
- You do not have to tell us your choice of OB-GYN before a preventive OB-GYN visit.

Choose your dental plan.

Applicant Name: _____

SSN: _____

The Affordable Care Act requires that we seek reasonable assurance from you that you and each individual on the policy have coverage for pediatric dental services (for children). The ACA considers coverage for pediatric dental services to be an essential health benefit that every policy must provide, even if there is no one on the policy who is eligible to use the coverage.

Companies like BCBSMT offer this dental coverage for children through "Marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

- For more information about these dental plan options, go to **bcbsmt.com/how-to-apply**.
- Dependents age 19 and older are considered adults for dental coverage.
- If you already have dental coverage with us, whatever you select here will REPLACE that current dental coverage.

Please **SELECT ONLY ONE OF THE THREE OPTIONS:**

OPTION 1 — Covers ADULTS WITH OR WITHOUT CHILDREN (choose one only)



FOR ADULTS



OR

ADULTS WITH CHILDREN

BlueCare Dental℠	INDIVIDUAL DEDUCTIBLE
☐ BlueCare Dental 1A	$25
☐ BlueCare Dental 1B	$50
☐ BlueCare Dental 1C	$50
☐ BlueCare Dental 1D	$50

OPTION 2 — Covers ONLY CHILDREN, UP TO AGE 19 (choose one only)

DO NOT CHOOSE if you chose a plan in option 1.



FOR CHILDREN ONLY

BlueCare Dental 4 Kids℠	INDIVIDUAL DEDUCTIBLE
☐ BlueCare Dental 4 Kids 1A	$25
☐ BlueCare Dental 4 Kids 1B	$50

OPTION 3 — Choose this option only if you already have dental coverage.

Check the box and sign here to tell us that you have what is known as a "Marketplace-certified stand-alone dental plan." Our records will show that you have the Pediatric Dental essential health benefit from BCBSMT or another company.

Note: Checking this option will NOT result in a change or cancellation to any existing coverage.

☐ **I/we already have coverage or are seeking coverage for pediatric dental essential health benefits through another policy.**

Signature (REQUIRED if selecting Option 3)	**Date**

Tell us how you will make your payments.

Applicant Name: _____

SSN: _____

Please be sure to read the important billing rules on the next page.

- Your plan may be canceled if you don't make a payment.
- **A valid personal email address is REQUIRED to set up electronic funds transfer.**
- **If you are a current member paying your premium via EFT**, please provide Premium Payment Information, even if there are no changes.

STEP 1 FIRST PAYMENT - select one

You may make your **first payment** by EFT, check or money order. Choose one:

☐ EFT (First payment will be taken from your account immediately.) ☐ Check (enclosed) ☐ Money order (enclosed)

TIP: Write the name of the Primary Applicant in the memo/notation on check or money order if different from name of account owner. **NOTE:** Use of a business account may require proof of compliance with Third Party Payment Rules on page 9.

STEP 2 MONTHLY PAYMENTS - select one

You may make your **monthly payments** by electronic funds transfer (Auto Bill Pay), or we can send you a bill by email or mail. Select your choice:

☐ EFT (Auto Bill Pay - valid email required) ☐ Bill by email (valid email required) ☐ Bill by mail

STEP 3 PAYMENT INFORMATION (ALL fields required if EFT selected for Step 1 or Step 2):

Please check one ☐ Checking account ☐ Savings account	**Name(s) on account if other than the Applicant**
Bank routing number (please verify)	**Account number** (please verify)
Email address	

AGREEMENT (See full Auto Bill Pay Terms of Use on page 9.)

I acknowledge that I have read the Auto Bill Pay Terms of Use on page 9, and I consent and authorize BCBSMT and/or its designee to take out monthly premium payments from my checking or savings account named above. Funds will be taken out on the last business day of the month before the next month of coverage. If the last usual business day (any M-F) of the month is a holiday or other nonbanking day, funds will be taken out on the prior business day. Withdrawals may be in the form of checks, share drafts or electronic debit entries. I also confirm I want my financial institution named here to honor the same payments from my account.

Account owner's signature	**Date**	**Relationship to Applicant**

Do not cancel any current coverage you may have until your Application is approved and your new plan is effective.

Your first month's payment is due when you sign up. If you are signing up for a new plan, **your coverage will not be in effect until we receive your first payment.**

Important billing rules.

Applicant Name: _____

SSN: _____

AUTO BILL PAY TERMS OF USE (email address required)

If you allow EFT, you understand and agree that BCBSMT and/or the company BCBSMT chooses to process payments may take monthly payments from your checking or savings account in accordance with the terms below:

- By signing up for Auto Bill Pay you authorize us and our service providers to store your payment information and charge your selected payment method on a monthly basis unless you take timely steps to cancel Auto Bill Pay. All such charges will be charged to your selected payment method on the last day of the month preceding the month of coverage until you cancel Auto Bill Pay. If that day occurs on a weekend day or Federal holiday, the draft will occur on the business day immediately prior. The amount you will be charged will be based on your premiums and other fees, charges and expenses chargeable to you. You will be notified by email if the amount of your payment changes.
- If you would like to cancel Auto Bill Pay please log in at **mybam.bcbsmt.com** or call **1-855-258-8471**. All requests for Auto Bill Pay cancellations must be received 3 business days or more before the payment is scheduled. Otherwise, Auto Bill Pay cancellation will be effective the next month.
- If your statement shows transfers that you did not make, including those made by card or other means, tell us at once by calling **1-855-258-8471**. If you do not tell us within 60 days after the statement was sent to you, you may not get back any money you lost after the 60 days if we can prove that we could have stopped someone from taking the money if you had told us in time. If a good reason (such as a long trip or a hospital stay) kept you from telling us, we will extend the time periods.
- If you have told us in advance to make regular payments out of your account, you can stop any of these payments. Here's how:
  - Call us at the phone number found on the back of your member ID card or log into your online account in time for us to receive your request 3 business days or more before the payment is scheduled to be made.
  - If these regular payments may vary in amount, we will tell you, 10 days before each payment, when it will be made and how much it will be.
  - If you order us to stop one of these payments 3 business days or more before the payment is scheduled, and we do not do so, we will be liable for your losses or damages.
- We may at any time and without notice amend these Auto Bill Pay Terms of Use. You should read these Auto Bill Pay Terms of Use. Your continued use of the Auto Bill Pay function after any such amendments will constitute your agreement to such change(s). We may discontinue Auto Bill Pay functionality for any reason and without notice, or require re-enrollment if terms or conditions are modified.

THIRD PARTY PAYMENT RULES

BCBSMT follows the premium payment process established by the Affordable Care Act in accordance with all federal requirements.

1. BCBSMT accepts premium payments from the following third-party entities on behalf of enrollees:
   a. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
   b. An Indian tribe, tribal organization or urban Indian organization; and
   c. A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

2. BCBSMT may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:
   a. For the entire coverage period of the enrollee's policy;
   b. Based solely on the financial status of the enrollees;
   c. Regardless of the coverage the enrollee chooses; and
   d. Regardless of the enrollee's health status.

3. BCBSMT may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.

4. BCBSMT will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (also known as ERISA) group health plan and either:
   a. The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or
   b. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

5. BCBSMT will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

Tell us about other coverage.

Applicant Name: _____

SSN: _____

COVERAGE YOU ARE REPLACING

Will this plan replace health coverage for 2027 you already have? **If yes, list all coverage that you plan to terminate and replace with a plan from BCBSMT and read KNOW YOUR RIGHTS below:** ☐ Y ☐ N

COVERED PERSON(S)	NAME OF INSURANCE COMPANY	POLICY NUMBER	TERMINATION DATE

KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, BCBSMT may NOT automatically cancel your old policy. This section confirms that you plan to cancel your current accident and health plan and replace it with a plan from BCBSMT. For your own information and protection, you should know how this decision may affect the coverage available to you in a new plan.

1. You may want to ask the company that offers the plan you are replacing about your decision. You could also talk to their agent. This is your right. It is in your best interest. You should be sure you understand all the issues you may have if you replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be sure to truthfully and completely answer all questions on this Application about any person applying for coverage. If you leave out any important information, BCBSMT may have a legal basis to deny any future claims and to refund your premium as though your contract had never been in force. Before you sign the completed Application, re-read it carefully to be sure that all information is correct.

OTHER COVERAGE YOU OR YOUR DEPENDENT(S) MAY HAVE

Does any person applying for coverage currently have, or did they previously have within the last 60 days:
- Coverage with BCBSMT?
- Health coverage with any other insurance company?
- Coverage under a tax-supported or government program, including Medicare?

If yes, please provide details below: ☐ Y ☐ N

Applicant Name	**Name on Other Policy** (if different)	**Member/Group ID** (recommended)
Applicant Name	**Name on Other Policy** (if different)	**Member/Group ID** (recommended)

Proxy Statement (OPTIONAL)

By purchasing a BCBSMT health plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company. By signing this Proxy Statement, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:
- This permission will apply to any company that replaces HCSC.
- The Board of Directors may appoint someone to vote for me.

The annual meeting of members is scheduled to take place each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called if needed. Notice of any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:
- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 12 to complete this Application.	**Date**
Print your name as you signed it:	

Please read and sign on next page.

Applicant Name: _____

SSN: _____

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Application is not coverage. Coverage will not begin until (1) the effective date of the plan and (2) the first month's payment is made.[1]
- If I use an agent, they cannot accept risks or change the policies or rules of BCBSMT.
- If an agent helps me purchase a new or renew a health plan, BCBSMT may pay them $17.00 to $25.00 per member per policy per month. My agents may also get bonus and marketing payments. These payments do not affect the amount I pay each month for my plan.
- If any person knowingly submits a false claim for payment of a loss or benefit or falsely misstates an important fact on this Application, coverage may be rescinded. This includes false claims or facts about me or any of my dependents. Rescission cancels the coverage back to the first day it became effective. I will be given at least 30 days' written notice before my coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the state's department of insurance and other applicable state and federal laws and regulations. Rates are calculated based on age, tobacco use and geographic rating factors. These factors are also used to calculate premiums for any dependents covered on my plan.
- I authorize any of the following people or organizations to share my health information with BCBSMT or their authorized representative:
  - Health professionals, hospitals, or clinics
  - Other health or health-related facilities
  - Government agencies
  - Pharmacy benefit managers, clearinghouses, or retail stores
  - Any other persons or firms required by law

  › This information may include:
  - Copies of records about advice, care or treatment that were given to me and/or my dependents
  - Information about the prescription and use of drugs or alcohol
  - Information about mental illness

  › BCBSMT may review and research its own records for information.

  › BCBSMT will share collected information only as needed with medical entities to help manage my care.

  › Information shared with my authorization may be re-shared by BCBSMT as allowed or required by law. If such sharing is required, the person or agency getting the information will be responsible for protecting it.

  › This authorization is valid for two years from today, or until I cancel coverage.
  - I have the right to cancel the authorization at any time, in writing, by contacting BCBSMT.
  - I or anyone I authorize to represent me will receive a copy of this authorization upon request.
  - Any cancellation will not affect the activities of BCBSMT before the date such cancellation is received by BCBSMT.
- I present any statements and answers on this Application as FACTS. To the best of my knowledge and belief, they are true and complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSMT and me.
- My agent (if I have one) and I confirm that I have read and understood the Application and reviewed the details of the plan I chose.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application, will pay BCBSMT directly.
- BCBSMT does not accept payments directly from third parties except from those listed on page 9.
- If these rules are broken, any payments made by a third party will not be credited to my account or coverage. These payments may not be refunded to me. This may result in the cancellation of my coverage for nonpayment.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF A HEALTH PLAN CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.

[1] Some exceptions apply during a Special Enrollment Period. Check with your agent or Customer Service.

Did you work with an agent?

Applicant Name: _____

SSN: _____

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given.
- I provided written material to explain the benefits to the Applicant(s). This includes details about what may not be covered and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes the Disclosure Statement(s) when requested.

Agent's Signature	**Agent's Printed Name**	**Date**
Agent ID	**Agent's Phone**	
Agent's Email		

Please read and sign below. (REQUIRED)

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PROCESSED

Primary Applicant's Printed Name AND Signature	**Date**
Parent or Legal Guardian of a Minor Child Printed Name AND Signature (if child is the Primary Applicant)	**Date**

If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:

Personal Representative's Printed Name AND Signature	**Relationship**	**Date**

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSSIBLE, REMEMBER TO:

- Sign your form.
- Send **ALL PAGES** of this form.
  - **INCLUDE EVEN BLANK PAGES**.
- If you are working with an agent, please include your agent's information above.
- Please include all supporting materials.
- If you are the Legal Guardian for anyone listed on the Application, please enclose a signed court decree.

PLEASE SUBMIT THIS FORM BY:

MAIL	Blue Cross and Blue Shield of Montana, Attn: Individual Enrollment, PO Box 660819, Dallas, TX 75266-0819
FAX	**1-800-279-7419**

Questions? If you have any questions, please call your agent or call BCBSMT toll-free at **1-844-525-6188**. Visit **discoverbcbsmt.com** for frequently asked questions about membership, payment and benefits.

BlueCross BlueShield of Montana

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@hcsc.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsmt.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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BlueCross BlueShield of Montana

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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