



**BlueCross BlueShield
of Montana**

Small Group

Group Enrollment Application | Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM
Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 ENROLLMENT EVENTS

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all sections where applicable.

Add Dependent: Complete all sections where applicable.

- If you are enrolling for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.

Open Enrollment: The period of time offered annually during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.

Special Enrollment Event: If you qualify, special enrollment is any change to your current membership such as marriage, divorce, adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.

Effective Date of Benefits: Field is mandatory and should reflect your requested date.

Completion of Other Eligibility Requirements: Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.

Cancel Enrollee/Cancel Dependent/Cancel Coverage: Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.

SECTION 2 YOUR INFORMATION

Complete this section with details about yourself even if you are declining coverage.

SECTION 3 YOUR COVERAGE

Complete all portions related to the coverages for which you are enrolling. Please list the seven character plan ID for your selected benefit design (example: B918PF) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

SECTION 4 COVERAGE OPTIONS

Complete all areas that apply to you and each dependent.

Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.

SECTION 5 DISABLED DEPENDENT

A disabled dependent must be medically certified as disabled and dependent upon you or your spouse in order to be considered for coverage if disabled dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the enrollment application, if applicable.

SECTION 6 OTHER COVERAGE

Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this enrollment application becomes effective.

SECTION 7 MEDICARE COVERAGE

Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.

SECTION 8 DECLINATION OF COVERAGE

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 8, not just those declining because of other coverage.

IMPORTANT NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption or placement of an eligible foster child in your home.

SECTION 9 COVERAGE CONDITIONS

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form [by mail or email] to: **BCBSMT • Enrollment Department**
• PO Box 59604 • Helena, MT 59604 • bcbs_eligibility_mt@bcbsmt.com.

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Montana website at bcbsmt.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM



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Group #

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Account

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Section #

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Social Security #

Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

New Enrollee **Add Dependent** **Open Enrollment** **Other Changes**

Are you enrolling as a result of a Special Enrollment Event?

No **Yes, Event Date:** ___/___/___

Event: New Hire Marriage Birth

Adoption (provide legal documents)

Court Order (provide court order or decree)

Loss of Other Coverage

Other (explain):

Effective Date of Benefits: ___/___/___ **Completion of Other Eligibility Requirements**

Cancel Enrollee **Cancel Dependent**

Cancel Coverage: Health Dental

List names of those canceling in Section 4 below

Event: Divorce Death

Terminated Employment Other

Indicate Event Date: ___/___/___

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

| | | | | | |
|-----------|------------|----------|--------|-------------------------|-------------------|
| Last Name | First Name | MI (opt) | Suffix | Birth Date (MM/DD/YYYY) | Social Security # |
|-----------|------------|----------|--------|-------------------------|-------------------|

| | | | |
|----------------------------------|------|-------|----------|
| Mailing Address - Street - Apt # | City | State | ZIP code |
|----------------------------------|------|-------|----------|

| | | |
|---------------|---|-------------------|
| Email Address | <input type="checkbox"/> Male <input type="checkbox"/> Female | Home/Cell Phone # |
|---------------|---|-------------------|

| | | | | |
|------------------|-----------|------------------|------------------------------|---|
| Name of Employer | Job Title | Business Phone # | Employment Date (MM/DD/YYYY) | On average, how many hours a week do you work? (required) |
|------------------|-----------|------------------|------------------------------|---|

Eligibility Status: Active Employee Retired Employee - Date of Retirement: _____ COBRA Continuation

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Blue Preferred PPOSM Health and Vision (if vision is offered)

Blue Preferred PPOSM

Other:

7-character Plan # (required) _____

Blue FocusSM Health and Vision (if vision is offered)

Blue FocusSM

Other:

7-character Plan # (required) _____

BlueCare DentalSM

Dental Option must be offered by Employer

Primary Language:

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY

| | | | | |
|--------------------------|----------|-------|---|---|
| Employee/Enrollee's Name | PCP Name | PCP # | New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
|--------------------------|----------|-------|---|---|

| | | | | | |
|--|-------------------------------|----------------------|-------|---|---|
| Dependent's Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife | Dependent's Social Security # | Dependent's PCP Name | PCP # | New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
|--|-------------------------------|----------------------|-------|---|---|

| | | | | |
|-------------------------|---|--|--|--|
| Birth Date (MM/DD/YYYY) | Address (if different) - # and Street Address, City, State, ZIP | | | |
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| | | | | | |
|---|-------------------------------|----------------------|-------|---|---|
| Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent | Dependent's Social Security # | Dependent's PCP Name | PCP # | New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
|---|-------------------------------|----------------------|-------|---|---|

| | | | |
|-------------------------|---|--|--|
| Birth Date (MM/DD/YYYY) | Address (if different) - # and Street Address, City, State, ZIP | Is this dependent a natural child, stepchild, adopted child or foster child? <input type="checkbox"/> Y <input type="checkbox"/> N | If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N |
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|---|-------------------------------|----------------------|-------|---|---|
| Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent | Dependent's Social Security # | Dependent's PCP Name | PCP # | New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
|---|-------------------------------|----------------------|-------|---|---|

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| Birth Date (MM/DD/YYYY) | Address (if different) - # and Street Address, City, State, ZIP | Is this dependent a natural child, stepchild, adopted child or foster child? <input type="checkbox"/> Y <input type="checkbox"/> N | If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N |
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|---|-------------------------------|----------------------|-------|---|---|
| Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent | Dependent's Social Security # | Dependent's PCP Name | PCP # | New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision |
|---|-------------------------------|----------------------|-------|---|---|

| | | | |
|-------------------------|---|--|--|
| Birth Date (MM/DD/YYYY) | Address (if different) - # and Street Address, City, State, ZIP | Is this dependent a natural child, stepchild, adopted child or foster child? <input type="checkbox"/> Y <input type="checkbox"/> N | If not your eligible natural child, stepchild, adopted child or foster child, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N |
|-------------------------|---|--|--|

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

| | |
|--------------------------|---|
| Español Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. |
| العربية Arabic | إن كان لديك أو لدى شخص تساعد أسئلة، فلدليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文 Chinese | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。 |
| Français French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984. |
| Deutsch German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. |
| ગુજરાતી Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બાજુ વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો. |
| हिंदी Hindi | यदि आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें। |
| Italiano Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어 Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné Navajo | T'áá ni, éí doodago ła'da biká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'ídílkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984. |
| فارسی Persian | اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید. |
| Polski Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Tagalog Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |



Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication 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, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>