BlueCross BlueShield Minnesota

Eligible 1/1/2026

2026 BI-WEEKLY

	HIGH VALUE	AWARE
EMPLOYEE	$0.00	$25.64
EMPLOYEE + 1	$320.22	$395.26
FAMILY	$650.60	$764.97

A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name	First name	M.I.	Date of Birth	Social Security Number	Home phone
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Employee's Home address	Street	City	State	Zip code	Work phone

Employee's Email address

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

Relation	Last name	First name	M.I	Cancel Eff. Date	Add/ Cancel	Sex	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #
Self					☐ Add ☐ Cancel	M / F ☐☐	☐ Married ☐ Single			
Spouse					☐ Add ☐ Cancel	M / F ☐☐	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F ☐☐	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F ☐☐	☐ Married ☐ Single			
Child Stepchild					☐ Add ☐ Cancel	M / F ☐☐	☐ Married ☐ Single			

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

☐ Elect or ☐ Waive Health (self)
☐ Elect or ☐ Waive Health (dependents)

IF YOUR EMPLOYER OFFERS ANCILLARY COVERAGE PLEASE CHECK APPROPRIATE BOXES TO ELECT OR WAIVE:

☐ Elect or ☑ Waive Dental (self)
☐ Elect or ☑ Waive Dental (dependents)
☐ Elect or ☑ Waive Vision (self)
☐ Elect or ☑ Waive Vision (dependents)

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

X	Month Day Year
Signature of employee	Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

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

Group numbers:
Health _____ Dental _____ Vision _____
Department number _____ Class _____

Monthly salary (Complete only if applying for salary-based benefits) $ _____

Indicate the reason employee is enrolling for coverage:

☐ New employee
☐ Rehire (length of layoff) _____
☐ New group
☐ Return from leave of absence (length of absence) _____
☐ Previously waived coverage
☐ Change from part-time to full-time
☐ Certificate of coverage termination
☐ Other _____
Date of event: _____

I certify the above information to be true and correct.

Signature _____ Date _____

Employer name	Telephone number	Fax number

E. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage?
☐ Yes ☐ No

If yes, you must complete the following: (Medicare: List both Part A and B effective dates)

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (Single or Family)	Effective date

If Medicare: check reason for entitlement: ☐ Age ☐ Disability ☐ End-Stage Renal Disease
☐ Disability & Current End-Stage Renal Disease

F. COVERAGE CHANGE INFORMATION – CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B and C

Adding dependents: Date of event

☐ Birth/adoption _____
☐ Court order _____
☐ Marriage _____
☐ Other _____

Cancelling dependents: Date of event

☐ Divorce _____
☐ Other (explain) _____

County _____
Details _____

Loss of prior health coverage:

Date of event

☐ Other coverage voluntarily terminated _____
☐ Group continuation (COBRA) period exhausted _____
☐ Employer contribution for coverage terminated _____
☐ Coverage terminated due to loss of eligibility _____

☐ Address change
☐ Primary care clinic change
☐ Phone number change
☐ Name change

Reason _____

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 64024
St. Paul, Minnesota
55164-0024