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an association of independent Blue Cross and Blue Shield Plans.

# Application and/or Waiver of Coverage for Group Benefit Plans

**BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)  
PO BOX 4309  
HELENA MT 59604**

## **Important Notices**

### **Please Read Prior to Completing this Application**

**Special Enrollment Rights:** If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible to enroll yourself and/or your dependents in this plan, provided you request enrollment within 31 days after your other coverage ends due to loss of eligibility or the employer ceases contribution toward that coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

**Preexisting Condition Exclusion Period:** The plan in which you are enrolling may have a preexisting exclusion period before preexisting conditions are covered. Your employer will give you a notice of any preexisting condition exclusion period when you receive this application.

**Please do not sign this application until your employer provides you with a notice of the preexisting condition exclusion period.**

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Applicant/Subscriber Name: \_\_\_\_\_

## APPLICATION AND/OR WAIVER OF COVERAGE FOR GROUP BENEFIT PLANS

PLEASE PRINT IN BLACK INK

<b>Purpose</b>	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Family Member <input type="checkbox"/> Transfer (Current ID Number)  <input type="checkbox"/> Waive Coverage	<b>Plan Applying For</b>		<b>IMPORTANT</b>
		<input type="checkbox"/> Traditional <input type="checkbox"/> PPO <input type="checkbox"/> Other	<input type="checkbox"/> Managed Care <input type="checkbox"/> Big Sky Select <input type="checkbox"/> Blue Select	

**Warning!** Waiver of coverage may result in you and/or your dependents being treated as a "late enrollee." Future enrollment will be limited to special enrollment and open enrollment time periods, should they occur. Additionally, you and/or your dependents may be subject to a preexisting condition waiting period for benefits.

<b>Applicant/Subscriber</b>	ENROLLING	WAIVING	Last Name	First Name	MI	Social Security Number (SSN) <small>Your SSN may be included in your Subscriber Identification Number.</small>	Date of Birth <small>(mo   day   yr)</small>	Male/ Female	
	Applicant/Subscriber Mailing Address					City	State	ZIP Code	Work Telephone
	Personal Care Physician (PCP) Name and City <small>(required only for Managed Care Plans)</small>						Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married* <small>*Complete spouse's information below.</small>	Date of Marriage <small>(mo   day   yr)</small>	

<b>Spouse and Dependent(s)</b>	ENROLLING	WAIVING	All family members must be listed. Indicate for each family member whether enrolling or waiving coverage.				Male/Female						
			Last Name	First Name	MI	Social Security Number	Date of Birth <small>(mo   day   yr)</small>	Relationship	Personal Care Physician Name and City <small>(required only for Blue Select)</small>				

<b>Waiving Coverage</b>	Is the Applicant/Subscriber covered under another health plan or agreement? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
	If yes, is the Applicant/Subscriber covered under another health plan or agreement as a dependent spouse? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
	If waiving coverage, is it due to coverage under a group health plan or agreement as a dependent spouse/child? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
By my signature, I AM WAIVING COVERAGE FOR MYSELF AND ALL FAMILY MEMBERS. (If not waiving coverage, complete the application.)										
Applicant/Subscriber, sign here <u>only</u> if Waiver of Coverage is for <u>all</u> family members: _____ Date: (mo   day   yr) _____										
If you have signed above to waive coverage for yourself and all family members, it is not necessary to complete the rest of this form; however, your employer must complete the employer section on page 4 prior to submitting the form to BCBSMT.										

<b>BCBSMT OFFICE USE ONLY</b>	Group Number			Small Group <input type="checkbox"/> Yes <input type="checkbox"/> No		BCBSMT Date Stamps					
	CT	Package	Dept.								
	Probationary Period		Effective Date		<input type="checkbox"/> New Employee <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Late Enrollee <input type="checkbox"/> New Group						
	Underwriter Initials			BC:	Mailed:						

**This section must be completed for all Applicants/Subscribers.**

Other Coverage Information	<b>Creditable Coverage:</b> ♦ Including, but not limited to Medicare, Medicaid, employer-based insurance, or health insurance coverage. ♦ Does not include limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy. <b>Creditable Coverage:</b> If you or your dependents had health coverage within the last 63 days or within 63 days of the date on which a certificate of creditable coverage was issued (not including days required to satisfy the employer's probationary waiting period before the member is eligible to apply), the preexisting condition exclusion period will be reduced by the combination of the periods of Creditable Coverage that the member had as of the enrollment date of this plan. In addition, please attach verification of Creditable Coverage to this form <b>OR</b> complete the following information for you and your dependents. The previous health insurance carrier must provide a certificate of Creditable Coverage with the end date of that coverage. BCBSMT will assist you or your dependents, if necessary, in obtaining this certificate or the necessary information from previous health insurance carriers. <b>Have you or your dependents had health coverage within the last 63 days?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents.</b> <b>Loss of Eligibility for Other Coverage:</b> If you are enrolling because you <b>lost eligibility</b> for other health coverage or the employer ceased the employer's contribution toward that coverage, please <b>indicate below for each person applying due to a loss of eligibility</b> . Application for enrollment based on loss of eligibility must be received by BCBSMT within 31 days of the date the eligibility for the other health coverage ends. Please fill out the following to verify Creditable Coverage or loss of eligibility if applicable. <p style="text-align: center;"><b>Warning: Omissions or incomplete answers may cause delay</b></p>					
	Name of Person Covered (include last name if different from Applicant/Subscriber)		Self: ID #:	Spouse: ID #:	Dependent: ID #:	Dependent: ID #:
	Loss of Eligibility		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Full Name, Address, and Telephone Number of Insurance Company or Carrier					
	Check Type of Coverage		<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
	Enrollment Date	From	(mo   day   yr)	(mo   day   yr)	(mo   day   yr)	(mo   day   yr)
	Cancel Date	To				
	Will this coverage be continued?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	*ID # is your identification number under previous or current insurance company or carrier.					

**This section is required for employees enrolling themselves and/or their dependents on a small employer<sup>†</sup> group plan.**

<sup>†</sup>Ask your employer whether you need to complete the Medical History section.

<b>If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.</b>								
Medical History	<b>A. List current height and weight for all persons to be covered age 12 and older.</b>							
	Name of Person		Current Height	Current Weight	Name of Person		Current Height	Current Weight
	<b>B. Within the last three (3) years, have medications (except antibiotics) been prescribed for, been provided for (e.g., samples, injections), and/or been taken by any person to be covered?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please explain below.</b>							
	Name of Person	Name of Medication and How Often Refilled	Daily Dosage	Condition for Which Medication Was Prescribed or Taken	Dates From To (mo   day   yr) (mo   day   yr)		Complete Provider Name (First and Last)	
	<b>C. Does any family member, whether applying for coverage or not, have reason to believe that she or he is an expectant mother or father (by positive result of a home pregnancy test, provider test, laboratory results, etc.)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, name of person(s) and due date(s):</b> Explain any signs of complications:							

Applicant/Subscriber Name: \_\_\_\_\_

**If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.**

Medical History

**D. Has any person to be covered EVER had or been diagnosed with any of the following?**  
 Yes  No If yes, please explain below.

1. <input type="checkbox"/> AIDS or AIDS-Related Complex	6. <input type="checkbox"/> Congenital Defect	11. <input type="checkbox"/> Heart Murmur	17. <input type="checkbox"/> Seizure Disorder/Epilepsy
2. <input type="checkbox"/> HIV Positive	7. <input type="checkbox"/> Diabetes	12. <input type="checkbox"/> Heart Problems	18. <input type="checkbox"/> Alcohol Use
3. <input type="checkbox"/> Cancer	8. <input type="checkbox"/> Liver Disorder	13. <input type="checkbox"/> Rheumatic Fever	19. <input type="checkbox"/> Drug Use
4. <input type="checkbox"/> Tumor	9. <input type="checkbox"/> Colon or Intestinal Disorder	14. <input type="checkbox"/> Mental Disease	20. <input type="checkbox"/> Sleep Apnea
5. <input type="checkbox"/> Chemotherapy/Radiation Treatment	10. <input type="checkbox"/> Stroke or Circulatory Problems	15. <input type="checkbox"/> Blood or Coagulation Disorder	21. <input type="checkbox"/> Weight Loss Procedure (e.g., gastric bypass)

Condition Number (1-21)	Name of Person	Diagnosis/Condition	Dates		Hospitalized?	Complete Provider Name (First and Last) or Facility Name Address City State ZIP
			From (mo   day   yr)	To (mo   day   yr)		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**E. Has any person to be covered been diagnosed with, or treated or counseled for, any complaint, condition, illness, disorder, or disease relating to any of the following in the past five (5) years?**  Yes  No If yes, please explain below.

22. <input type="checkbox"/> Anxiety/Depression	30. <input type="checkbox"/> Osteopenia/Osteoporosis	38. <input type="checkbox"/> Allergy	46. <input type="checkbox"/> Hernia (specify type)
23. <input type="checkbox"/> Counseling	31. <input type="checkbox"/> Joints (specify area, left or right if applicable)	39. <input type="checkbox"/> Prostate	47. <input type="checkbox"/> High Blood Pressure (complete blood pressure table below in Section F)
24. <input type="checkbox"/> Eating	32. <input type="checkbox"/> Fractures	40. <input type="checkbox"/> Reproductive Organs	48. <input type="checkbox"/> Ulcer (specify type)
25. <input type="checkbox"/> Suicide Attempt	33. <input type="checkbox"/> Arthritis	41. <input type="checkbox"/> Infertility	49. <input type="checkbox"/> Ear (e.g., infection, hearing impairment)
26. <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD)	34. <input type="checkbox"/> Systemic or Discoid Lupus/Connective Tissue Disorder	42. <input type="checkbox"/> Urinary Tract	50. <input type="checkbox"/> Nasal/Sinus (e.g., infection, malformation, deviated nasal septum)
27. <input type="checkbox"/> Hyperactivity	35. <input type="checkbox"/> Kidneys	43. <input type="checkbox"/> Thyroid	51. <input type="checkbox"/> Eyes (e.g., crossed eyes, detached retina, cataract, glaucoma)
28. <input type="checkbox"/> Breasts	36. <input type="checkbox"/> Lungs	44. <input type="checkbox"/> Gastric Reflux (e.g., heartburn)	52. <input type="checkbox"/> Other
29. <input type="checkbox"/> Back/Neck (specify area)	37. <input type="checkbox"/> Asthma	45. <input type="checkbox"/> Headaches/Migraines	

Condition Number (22-52)	Name of Person	Diagnosis/Condition	Dates		Hospitalized?	Complete Provider Name (First and Last) or Facility Name Address City State ZIP
			From (mo   day   yr)	To (mo   day   yr)		
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**F. Blood Pressure readings must be provided if answered "Yes" to #47 above. (Give the three most recent readings, at least one month apart.)**

Name of Person	Date Taken (mo/yr)	Blood Pressure Reading	Date Taken (mo/yr)	Blood Pressure Reading	Date Taken (mo/yr)	Blood Pressure Reading
		/		/		/
		/		/		/

**G. Has any person to be covered received or been recommended to receive any medical treatment that has not been listed above? This includes counseling, follow-up for abnormal laboratory studies (including abnormal Pap smears), examinations/tests/laboratory studies/x-rays (MRI, CT scan, ECG, ultrasound, mammogram, etc.), or care recommended by physicians, other medical practitioners, or a legal authority.**

Yes  No If yes, please indicate whether the treatment has been received or recommended, and provide date(s), name(s) of person(s), and detailed explanation(s).

**H. Has any person to be covered been fitted with any implants or orthopedic device (including pins, screws, plates, or braces) or does any person regularly use durable medical equipment (e.g., a wheelchair, splints or crutches, oxygen, CPAP)?**

Yes  No If yes, please provide date(s), name(s) of person(s), and detailed explanation(s). Also, note whether orthopedic device(s) are temporary or permanent.

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To Be Completed by the Employer	Name of Group or Firm:		Group Number:		
	Name of Employee:		Occupation:		
	Current Number of Hours per Week	Date employee started working the required number of hours to become eligible for coverage. (This is the date BCBSMT will begin to calculate the probationary period for health care coverage.)			(mo   day   yr) : : : :
	Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Signature of Group Leader or Authorized Signer		Signature Date (mo   day   yr) : : : :	Please Print Name of Group Leader or Authorized Signer	
	<b>Informational</b> for Employee/Employer payroll deduction purposes only. <b>EMPLOYER:</b> Please refer to employee. Check Type of Coverage Applying for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Spouse/Child <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Spouse/Children				

**The sections below must be completed by Applicant/Subscriber.**

Conditions of Enrollment	<p><b>I/We certify and understand the following:</b></p> <ol style="list-style-type: none"> <li>I/We personally completed the Medical History section (if required) of this form, providing all requested information.</li> <li>All of the statements and responses in this application are complete, accurate, and current for the Applicant/Subscriber, and for the spouse and all dependents for whom coverage is requested</li> <li>This is an application only. No right is conferred to me or any person listed on this application until Blue Cross and Blue Shield of Montana enrolls me/us and dues (premiums) are paid.</li> <li>I/We understand that preexisting condition exclusion periods may apply and/or waiting periods for dental coverage.</li> <li>I/We, the undersigned, am/are applying for membership with Blue Cross and Blue Shield of Montana. I/We agree to the terms and conditions of any certificate issued to me/us by Blue Cross and Blue Shield of Montana.</li> <li>I/We understand that Blue Cross and Blue Shield of Montana maintains contracts with certain providers of medical services. I/We understand Blue Cross and Blue Shield of Montana will pay those providers and any other provider it chooses directly.</li> <li>I authorize my employer to pay dues (premiums) at the prevailing rates required by this application for membership with Blue Cross and Blue Shield of Montana. I understand that I may be required to pay a portion of the dues (premiums).</li> </ol>																
Conditions of Enrollment for Managed Care — Applicant/Subscriber Only	<p><b>This section applies to all Managed Care Plans.</b></p> <ol style="list-style-type: none"> <li><b>For Managed Care Applicant/Subscriber:</b> I/We have reviewed the Managed Care literature. I/We understand that this form of health care coverage is based on a partnership between me/us and my/our Personal Care Physician (PCP). I/We have reviewed and I/we understand the policies relating to urgent and emergency care, payment of services, and copayments.</li> <li><b>For Managed Care Applicant/Subscriber Living or Working Within 30 Miles of a Managed Care Network of PCPs:</b> I/We acknowledge that Blue Cross and Blue Shield of Montana has a Managed Care Network of PCPs within 30 miles of my/our place(s) of residence or work. However, I/we have voluntarily chosen a Managed Care PCP located farther than 30 miles from my/our place(s) of residence or work. Please initial below:           _____ Applicant/Subscriber    _____ Spouse    _____ Dependent 18 and over    _____ Dependent 18 and over    _____ Dependent 18 and over</li> </ol>																
Signature(s)	<p>I/We understand and agree that the coverage I/we am/are applying for is subject to the employer's eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I/We have read the Conditions of Enrollment. I/We understand and agree to them.</p> <p style="text-align: center;"><i>Must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying.</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Signature(s) <small>DO NOT PRINT</small></th> <th style="width: 15%;">Signature Date <small>(mo   day   yr)</small></th> <th style="width: 25%;">Signature(s) <small>DO NOT PRINT</small></th> <th style="width: 15%;">Signature Date <small>(mo   day   yr)</small></th> </tr> </thead> <tbody> <tr> <td>Applicant/Subscriber</td> <td style="text-align: center;">: : : :</td> <td>Spouse</td> <td style="text-align: center;">: : : :</td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;">: : : :</td> <td>Dependent</td> <td style="text-align: center;">: : : :</td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;">: : : :</td> <td>Dependent</td> <td style="text-align: center;">: : : :</td> </tr> </tbody> </table>	Signature(s) <small>DO NOT PRINT</small>	Signature Date <small>(mo   day   yr)</small>	Signature(s) <small>DO NOT PRINT</small>	Signature Date <small>(mo   day   yr)</small>	Applicant/Subscriber	: : : :	Spouse	: : : :	Dependent	: : : :	Dependent	: : : :	Dependent	: : : :	Dependent	: : : :
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