BlueCross BlueShield of Minnesota

ST. OLAF COLLEGE

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

Employee's Last Name	First Name	M.I.	Social Security Number	Home Phone ( )
Employee's Home Address	Street	City	State	Zip Code	Work Phone ( )

Relation (circle)	Last Name	First Name	M.I	Add / Cancel	Sex (circle)	Marital Status	Social Security #	Birth Date (Mo.Day Yr.)		
SELF				☐Add ☐Cancel	M / F	☐Single ☐Married				
SP/CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				
CH				☐Add ☐Cancel	M / F	☐Single ☐Married				

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

Coverage Level: ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ Waive

Plan: ☐ Core/Traditional Plan ☐ High Deductible Health Plan

Do you have coverage through more than one health insurance contract and/or Medicare?
☐ Yes ☐ No

Employee Electronic Signature Usage Agreement:
When electronic signatures are used, federal law requires that we inform you of the following:

- By signing below, I consent to electronic processing of this application to include use of my electronic signature.
- I acknowledge that Electronic Signature means that I am the person identified on this application as the applicant, that I voluntarily accept all the terms and conditions as stated in this application, and that I agree to the electronic processing of this record.
- I acknowledge that my electronic signature will have the same legal effect as a signature on paper.
- I acknowledge that I have the right to print and keep this application on paper.
- I acknowledge that I have the right to withdraw my consent to the electronic signature on this application. I understand I must notify my benefit providers in writing of my withdrawal of consent and that such withdrawal will not affect actions already taken by my benefit providers.
- I acknowledge that my consent to the use of my electronic signature applies to this application only and not to any other transactions with my benefit providers. I hereby apply for coverage on the basis of the statements and answers to the questions herein.

I hereby declare all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. Furthermore, I understand that this application must be updated by me to include any condition of disease which may occur between the date of my application and the Effective Date of Coverage. I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified for the Effective Date.

Employee Enrollment Acceptance:
I understand that providing false information or omission of relevant information in this application may result in the denial of claims or cancellation or rescission of coverage.

I Agree to the Usage Agreement and Acceptance statements mentioned above.

X	Month	Date	Year
Signature of Employee	Date signed		

D. THIS PART TO BE COMPLETED BY EMPLOYER

Group Numbers:
Health _____ Reason: Effective Date:

I certify the above information to be true and correct.
Signature: Travis Grant, Benefits Specialist Date:

Employer Name: St. Olaf College	Telephone number: 507-786-6689	Fax number: 507-786-3960

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