Application for Individual Plan Health Insurance

Complete this application in its entirety in blue or black ink.
Do not use a pencil or a highlighter.

Eff. 1/1/2024
Filed 10/16/2023
BND-22-0059565 IND FI
10-23

STEP 1: APPLICANT'S INFORMATION

Please note: Processing of your application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) _____		Requested Effective Date _____
Physical Address			Apt. or Suite Number
City	County	State	ZIP
Mailing Address *(If different than physical address)*			Apt. or Suite Number
City		State	ZIP
Home Phone	Work Phone	Mobile Phone	
Email Address *(If applicable)*			

Tobacco Use?* ☐ Yes ☐ No

*Question is required and must be completed or your application will be delayed. See back page for further clarification.

STEP 2: CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. The plan and deductible option you choose will apply to everyone covered by your plan.

Benefit Plans:

- ☐ BluePrime Gold 70 500 (10523796)
- ☐ BlueDirect Gold 90 2600 (10353824)
- ☐ BlueDirect Silver 80 3500 (10353825)
- ☐ BlueDirect Silver 80LP 3300 (10430436)
- ☐ BlueDirect Bronze 100 7500 (10353826)
- ☐ BlueCare Gold 70 2000 (10353828)
- ☐ BlueCare Silver 60 3000 (10353829)
- ☐ BlueCare Silver 60LP 2900 (10430437)
- ☐ BlueEssential 100 9450 (10353830)
- ☐ BlueValue Gold 75 1500 (10743570)
- ☐ BlueValue Silver 60 5900 (10745086)
- ☐ BlueValue Bronze 50 7500 (10745087)
- ☐ DakotaBlue Altru Gold 70 2000 (10754873)
- ☐ DakotaBlue Altru Silver 60 3000 (10754874)
- ☐ DakotaBlue Altru Silver 60LP 2900 (10754872)
- ☐ DakotaBlue Trinity Gold 70 2000 (10823098)
- ☐ DakotaBlue Trinity Silver 60 3000 (10823097)
- ☐ DakotaBlue Trinity Silver 60LP 2900 (10823096)

☐ Yes ☐ No	Will any portion of the premium be paid by your employer or your spouse's employer, either directly or through wage adjustments or other means of reimbursement?
☐ Yes ☐ No	Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code? (See back page "Coverage Information" for additional explanation.)
☐ Yes ☐ No	Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B?
☐ Yes ☐ No	Is the plan an Individual Coverage Health Reimbursement Arrangement (ICHRA)? If yes, we are unable to enroll you in a BCBSND plan.

STEP 3: REASON FOR APPLYING

☐ **New coverage** (I do not have BCBSND coverage now) ☐ Change in existing BCBSND coverage Coverage End Date _____

Loss of previous health coverage due to:

- ☐ Legal Separation/Divorce
- ☐ Death
- ☐ Termination of Employment/Reduction of Hours
- ☐ Employer Contribution Terminated
- ☐ Loss of COBRA (Benefits Exhausted)
- ☐ Loss of Medicaid
- ☐ Other _____

Termination letter from previous carrier identifying the reason for loss of coverage is required.

Life event:	**Supporting documentation required:**
☐ Annual Enrollment	None
☐ Marriage	Marriage certificate
☐ Birth	Birth certificate
☐ Adoption	Adoption papers
☐ Legal Guardianship	Legal guardianship papers
☐ Permanent Move	Termination explanation from previous insurer
☐ Turning 26 (Aging Off Plan)	Termination explanation from previous insurer
☐ Court Order	Court Papers

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) ______________	Relationship to You? ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian	
Tobacco Use?* ☐ Yes ☐ No			

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) ______________	Relationship to You? ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian	
Tobacco Use?* ☐ Yes ☐ No			

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) ______________	Relationship to You? ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian	
Tobacco Use?* ☐ Yes ☐ No			

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) ______________	Relationship to You? ☐ Spouse ☐ Child ☐ Stepchild ☐ Grandchild ☐ Adopted ☐ Legal Guardian	
Tobacco Use?* ☐ Yes ☐ No			

*Question is required and must be completed or your application will be delayed. See back page for further clarification.

STEP 5: SIGN, AUTHORIZE AND DATE APPLICATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively canceling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X	
Applicant's Signature or Responsible Adult if Applicant is under age 18	Date Signed

Producer Number	**Producer Name**	**Producer Signature**

Tobacco Use

You should answer "Yes" to the Tobacco Use question if you, your spouse or any of your Eligible Dependents (age 21 or older as of the requested effective date) have, within the past six months, used tobacco regularly (four or more times per week on average, excluding religious or ceremonial uses).

Coverage Information

I understand if I pay any portion of my health insurance premiums using pretax dollars (Section 125) or my employer pays any portion of my health insurance premiums (Section 106) or provides reimbursement for uninsured medical expenses for me and my dependents (Section 162), I should answer "yes" to the question, "Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code?" (located in Section 2, Choose Your Plan).

Who is eligible for the BlueEssential catastrophic plan?

The BlueEssential catastrophic plan may only be offered to individuals who are under age 30 as of the requested effective date.

BlueDirect Benefit Plans

This overview describes a high deductible health plan designed to comply with Section 223 of the Internal Revenue Code and intended for use with a Health Savings Account (HSA)*. Blue Cross Blue Shield of North Dakota (BCBSND) is not authorized to provide legal or tax advice to members. BCBSND expressly disclaims responsibility for, and makes no representation or warranty regarding: (1) the eligibility of any member to establish or contribute to an HSA; or (2) the suitability of this product in all circumstances for use with HSAs.

*Note: cost-sharing reduction health plans purchased through the health insurance exchange may not comply for use with HSAs.

Limitations and Exclusions

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

Contact Us

Visit us on the web: www.BCBSND.com | **Member Services toll-free:** 844-363-8457

Visit one of our offices:

Fargo Office
4510 13th Ave. S.
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Phone: (701) 277-2232

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