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 ( )
Employee's Email address			Dept #	Date of Hire

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.	Add/ Cancel	Sex	Marital status	Social Security #	Birth Date (Mo. Day Yr.)
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)

Health plan product name:

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

X

Signature of employee

Month Day Year
Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:

Indicate the reason employee is enrolling for coverage:

☐ New employee
☐ Return from leave of absence (length of absence) ______
☐ Previously waived coverage
☐ Certificate of coverage termination
☐ Rehire (length of layoff) ______
☐ Change from part-time to full-time
☐ Other ______
☐ New Group

Date of event: ______

Group numbers: Health ______ Plan ______ Location ______

I certify the above information to be true and correct.

Signature ______ Date ______

Employer name	Telephone number ( )	Fax number ( )

E. CURRENT COVERAGE

Starting with the employee, list each family member applying for our coverage and include information for all current coverage:

Family Member Name	Insurance Company (name and policy number)	Date Coverage Started	Date Coverage Ended	Reason for Termination

F. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? ☐ Yes (complete section below) ☐ No

Employee:

Effective Date Part A ______________ Effective Date Part B ______________ Medicare Claim Number ____________________________

Eligibility reason for Medicare: ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

Spouse:

Effective Date Part A ______________ Effective Date Part B ______________ Medicare Claim Number____________________________

Eligibility reason for Medicare: ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

G. 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 ________________

County ______________________________

Details ____

Cancelling dependents: Date of event

☐ Divorce ______________________________

☐ Other (explain) ______________________________

Loss of prior health coverage:

Did you lose 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

Previous ______________________________________

List new name in Section A

Reason ______________________________________

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

BlueLink TPA
P.O. Box 64668
St. Paul, Minnesota
55164-0668