



A. TRIBAL 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
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.)	PRC Eligible
Self				<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single			<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse				<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild				<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild				<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Stepchild				<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single			<input type="checkbox"/> Yes <input type="checkbox"/> No

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	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:	Hours worked per week:
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Monthly salary (Complete only if applying for salary based benefits): \$ _____

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 _____

I certify the above information to be true and correct.

Signature _____ Date _____

Employer name	Telephone number ()	Fax number ()
PRC Signature authorizing enrollee PRC eligibility:		Date

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	Cancelling dependents:	Date of event
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (explain)	_____
<input type="checkbox"/> Marriage	_____		
<input type="checkbox"/> Other	_____	County	_____
		Details	_____

Loss of prior health coverage:

Did you lose health coverage? _____

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