BlueLink TPA

An independent licensee of the Blue Cross and Blue Shield Association serving residents and businesses of Minnesota

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)
☐ Elect or ☐ Waive - Dental (self)
☐ Elect or ☐ Waive - Dental (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:

Indicate the reason employee is enrolling for coverage:

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

Group numbers: Health _____ Plan _____ Dental _____ 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 _____

Cancelling dependents: Date of event

☐ Divorce _____
☐ Other (explain) _____

County _____
Details _____

Loss of prior health and/or dental coverage:
Did you lose health coverage, dental coverage or both? _____

Date of event

☐ Other coverage voluntarily terminated _____
☐ Group continuation (COBRA) period exhausted _____
☐ Employer contribution for coverage terminated _____
☐ Coverage terminated due to loss of eligibility _____ Reason _____

☐ Address change
☐ Primary care clinic change
☐ Phone number change
☐ Name change

Previous _____
List new name in Section A

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

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