2025 Application for Individual/Family Plan Health Insurance

BlueCross BlueShield Minnesota

Please Complete Steps 1 – 9.

Step 1) Tell us about yourself.
Step 2) Tell us about your household.
Step 3) Choose a plan.
Step 4) Tell us if you have a Special Enrollment event.
Step 5) Tell us if you have other health insurance.
Step 6) Review Notification and authorization.
Step 7) Review Payment and billing information.
Step 8) Sign the Application.
Step 9) Send your completed Application (all pages) to Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus).

If this Application is being completed by an insurance agent/producer, please complete and return the Producer Attestation with the rest of the completed Application.

Need Help?

- **This information is available in other ways to people with disabilities or who need it translated into another language by calling 1-800-382-2000 (toll-free). For TTY, call 711.**
- **Need help choosing a plan or completing this Application?**
  For in-person help or over the phone: Visit bluecrossmn.com/advisors to connect with a Blue Cross Advisor.
  If you work with an insurance agent/producer: Please contact your agent/producer for assistance. Or call Blue Plus at 1-800-262-0823 and one of our representatives will be happy to assist you. **Hours: 8 a.m. to 6 p.m. Central Time, Monday through Friday.**
- **During the Open Enrollment Period, you can enroll online: shop.bluecrossmnonline.com/home**
- Pediatric dental coverage is an essential health benefit available for purchase through a separate contract. For additional information on available pediatric dental plans, please visit mnsure.org. Pediatric dental benefit coverage is provided by an independent company.
- A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and the Uniform Glossary are accessible at bluecrossmn.com or available free of charge when requested by calling one of the telephone numbers listed above.
- Eligible for a subsidy? If you're eligible for a subsidy, you can buy a health plan from us on MNsure, Minnesota's online health insurance marketplace. See if you qualify at **mnsure.org.**

Who Can Enroll in the Products on This Application?

- If eligible, coverage will be provided under an individual/family contract. Blue Plus does not issue individual coverage through an employer.
- You must be a resident of Minnesota. You may obtain our Residency Policy at bluecrossmn.com or at 1-800-262-0823 and one of our representatives will be happy to assist you.
- Applicants (you or any dependent) enrolled in or receiving benefits under Medicare Part A and/or Part B are not eligible to enroll in an individual commercial plan. If you enroll in a Blue Plus individual commercial plan, you must immediately notify Blue Plus if you (or any dependent) enroll in or obtain health insurance benefits under a Medicare program after submitting this Application or at any time during your period of coverage in the Blue Plus plan.

Who Can Pay My Premium?

- Generally, you pay your own premium.
- Blue Plus may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly by ineligible third parties. "Ineligible third parties" include any person or entity from which Blue Plus is not required by law to accept such third-party payments. This may include, for example, commercial entities, health care providers and suppliers, and other persons or entities with direct or indirect pecuniary interests. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic funds transfer. If you have questions about this third-party payment policy or whether Blue Plus will accept premium and cost-sharing payments made by a specific person or entity, please contact customer service at 1-800-382-2000 before you complete this Application.

How Do I Submit This Application?

- Complete this entire Application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete Applications will be returned to you to be completed. This may affect the date your coverage starts. This Application must be received at the home office of Blue Plus within 15 days of your signature. Incomplete Applications are null and void after 30 days.
- To submit your Application faster, use one of these options:
  Online: shop.bluecrossmnonline.com/home (during Open Enrollment Period only)
  By telephone: 1-800-262-0823

STEP 1 - Tell us about yourself

☐ Open Enrollment ☐ Special Enrollment

My Blue Cross or Blue Plus ID number: _____

I am a new Applicant:

☐ Applying for coverage for myself only ☐ Applying for coverage for myself and my dependents

☐ Applying for coverage on behalf of my child(ren).

Important: If you are applying on behalf of a child under the age of 18 for his or her own coverage on an individual policy, please complete this section with YOUR information, because you will be the contact person for your child.

I am currently enrolled in a Blue Plus individual plan:

☐ Adding a dependent ☐ Making a plan change

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. Please print clearly.

When you include Social Security numbers (SSNs), we can process your Application more efficiently, but you are not required to include them for your dependents or yourself.

First Name	Last Name and Suffix		
Social Security Number (If no SSN, write N/A)	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	
Permanent Home Address (No P.O. Boxes)			
City	State	ZIP	County
Correspondence Address (If different than Home Address)	Street	City	State ZIP
Billing Address (If different than Home Address)	Street	City	State ZIP
Primary Phone Number	Email Address		

STEP 1 - Continued

STEP 1 – Tell us about yourself - continued

1. I have been a permanent resident of Minnesota for a minimum of 183 days: ☐ Yes ☐ No
   Important: We can only offer coverage to permanent Minnesota residents. Refer to healthcare.gov for options in your state.
2. Will you or any other enrollee receive any premium or cost-sharing payments made by a specific person or entity, directly or indirectly, by an **ineligible** third party described on page 2? ☐ Yes ☐ No
3. Do you have an Individual Coverage Health Reimbursement Arrangement (ICHRA) through your employer? ☐ Yes ☐ No
4. Do you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) through your employer? ☐ Yes ☐ No
5. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
6. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer
7. Spoken Language*: ☐ English ☐ Spanish ☐ Other, please specify_____ ☐ Choose not to answer
8. Written Language*: ☐ English ☐ Spanish ☐ Braille ☐ Other, please specify_____ ☐ Choose not to answer

☐ Ethnic background and race is the same for all dependents. If checked, ethnic background and race do not need to be selected for dependents within the following section.

STEP 2 – Who will be on the plan?

This section should be used to list all dependents applying for coverage.

Dependent 1	Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name / Last Name				☐ Male ☐ Female

1. Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No
   If No, list address: _____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 2	Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
First Name / Last Name				☐ Male ☐ Female

1. Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No
   If No, list address: _____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

STEP 2 - Continued

STEP 2 – Who will be on the plan? continued

Dependent 3 First Name	Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
Last Name				☐ Male ☐ Female

1. Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No
   If No, list address: _____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian
   ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 4 First Name	Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
Last Name				☐ Male ☐ Female

1. Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No
   If No, list address: _____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian
   ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

Dependent 5 First Name	Relationship to you	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Gender
Last Name				☐ Male ☐ Female

1. Does this dependent live at the same address as the Primary Applicant? ☐ Yes ☐ No
   If No, list address: _____
2. Ethnic Background*: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Choose not to answer
3. Race (Select one or more)*: ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian
   ☐ American Indian or Alaskan Native ☐ Other, please specify_____ ☐ Choose not to answer

☐ Additional dependent(s) on attached page.

* We may use this information to address differences in health care and improve communication with our members. Providing this information is voluntary and will not affect your benefits or coverage, how much you pay, or how we pay your claims.

GO TO STEP 3

STEP 3 – Choose your plan

Find your county and choose your plan. Before selecting a plan, make sure your provider is in network for that plan. Not every provider is in every network, and not every plan is available statewide. **For assistance, use our Find a Doctor tool:** bluecrossmn.com.

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan. Place an "X" in the correct check box. The plan you choose will apply to everyone covered by your plan. For plans with more than one person (family plan), no one member will exceed the single in-network deductible amount listed below. Also, eligible costs incurred by all covered family members count toward satisfying the family in-network deductible.

I am/we are applying for coverage under:

Blue Plus Metro MN - Single/Family Plans

Available for residents in the following counties: Anoka, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, McLeod, Nicollet, Ramsey, Scott, Sherburne, Sibley, Washington, Wright

- ☐ Blue Plus Metro MN Gold Rx Copay $1,200/$3,600 Plan 254
- ☐ Blue Plus Metro MN HSA Silver $3,300/$9,900 Plan 253
- ☐ Blue Plus Metro MN HSA Bronze $8,300/$16,600 Plan 258
- ☐ Blue Plus Metro MN Bronze $7,750/$15,500 Plan 259

Blue Plus Southeast MN - Single/Family Plans

Available for residents in the following counties:
Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan, Winona

- ☐ Blue Plus Southeast MN Gold Rx Copay $1,200/$3,600 Plan 272
- ☐ Blue Plus Easy Compare Gold and Rx Copay Blue Plus Southeast MN Plan 275
- ☐ Blue Plus Easy Compare Silver and Rx Copay Blue Plus Southeast MN Plan 273
- ☐ Blue Plus Southeast MN HSA Silver $$3,300/$9,900 Plan 271
- ☐ Blue Plus Southeast MN HSA Bronze $8,300/$16,600 Plan 270
- ☐ Blue Plus Easy Compare Bronze Blue Plus Southeast MN Plan 274

Blue Plus Minnesota Value - Single/Family Plans

Available for residents in the following counties:
Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Douglas, Grant, Hennepin, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Lincoln, Lyon, Mahnomen, Marshall, McLeod, Meeker, Mille Lacs, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rock, Roseau, Scott, Sherburne, Sibley, St. Louis, Stearns, Stevens, Swift, Todd, Traverse, Wadena, Washington, Wilkin, Wright, Yellow Medicine

- ☐ Blue Plus Minnesota Value HSA Gold $3,300/$9,900 Plan 207
- ☐ Blue Plus Easy Compare Gold and Rx Copay Blue Plus Minnesota Value Plan 205
- ☐ Blue Plus Minnesota Value Gold Rx Copay $1,200/$3,600 Plan 202
- ☐ Blue Plus Easy Compare Silver and Rx Copay Blue Plus Minnesota Value Plan 204
- ☐ Blue Plus Minnesota Value HSA Silver $3,300/$9,900 Plan 201
- ☐ Blue Plus Minnesota Value Bronze $7,750/$15,500 Plan 206
- ☐ Blue Plus Minnesota Value Bronze $5,800/$11,600 Plan 203
- ☐ Blue Plus Minnesota Value HSA Bronze $8,300/$16,600 Plan 200
- ☐ Blue Plus Easy Compare Bronze Blue Plus Minnesota Value Plan 208

The deductible, copay and out-of-pocket maximum amounts are subject to annual adjustments.

GO TO STEP 4

STEP 4 - Special Enrollment

A Special Enrollment Period is defined as a period during which you and your family have a right to sign up for new or make changes to existing health coverage. Special Enrollment Period qualifying life events include, but are not limited to, certain permanent moves, certain changes in your income, changes in your family size (e.g., giving birth to or adopting a child or getting married) or a loss of coverage. If you are enrolled in a plan that counts as minimum essential coverage, in most instances consumers have 60 days from the occurrence of the qualifying life event to sign up for or make changes to existing coverage; however, there are some instances defined in the chart below that allow 60 days before and after a qualifying life event to sign up for or make changes to existing coverage.

This Special Enrollment Period section within this Application CANNOT be used to make changes to coverage purchased from MNsure or to purchase new coverage from MNsure. To make such changes or purchases, you must contact MNsure directly.

If you would like to enroll in or change plans due to a qualifying life event, you must complete this Special Enrollment section and include or attach any necessary supporting documents. Select the appropriate qualifying life event below. The listing of qualifying life events is subject to change. If you do not see the qualifying event that describes your situation, please contact us at 1-800-262-0823

All materials, including supporting documents, must be provided before coverage will begin. Failure to provide all materials, including any supporting documents (listed below) to prove eligibility, may delay your Application or cause you to be denied coverage. Supporting documents must include, date of change or termination and everyone that will be covered by the plan. See Supporting Documents below for additional required information.

Date of qualifying life event: _____

Qualifying Life Event	Coverage Effective Date **Note:** The coverage effective date cannot be prior to the occurrence of the event.	Supporting Documents
☐ Loss of pregnancy related or medically needy coverage under Medicaid ☐ Loss of minimum essential coverage (MEC) (includes but is not limited to) ☐ Loss of eligibility for employer-sponsored coverage due to job loss or reduction in hours ☐ Employer no longer offers benefits or closes ☐ Legal separation/divorce from policyholder ☐ Employee/policyholder becomes Medicare-entitled ☐ Death of policyholder ☐ Child loses dependent status ☐ Loss of eligibility for Medicaid, MinnesotaCare or CHIP ☐ Expiration of COBRA or non-calendar year policy or loss of employer COBRA contributions ☐ Moving out of existing ACO or HMO plan service area	Notification can be 60 days prior to and 60 days after the loss of coverage: • If the plan selection is before or on the date of loss of coverage, the effective date is the first day of the month following the loss of coverage • If the plan selection is after the loss of coverage, the effective date is the first day of the month following the plan selection **NOTE:** Voluntarily quitting other health coverage and being terminated for not paying premiums are not considered losses of minimum essential coverage. Losing health coverage that is not minimum essential coverage is also not considered a loss of minimum essential coverage.	Documentation showing loss of coverage, including: • Termination date • People covered by the plan • Reason for termination ☐ Letter of termination from carrier (includes dependent age maximum reached) ☐ Notice of termination of government-sponsored coverage ☐ Letter/notice of termination of benefits from the employer (includes divorce from policyholder, death of policyholder or policyholder becomes Medicare-entitled) ☐ COBRA eligibility notice ☐ Documentation showing that COBRA coverage or non-calendar year policy is ending ☐ Letter of termination from carrier/ insurance company and proof of address change
☐ A permanent move to a new area that offers different health plan options. You must have had minimum essential coverage (MEC) for one or more days during the 60 days preceding the permanent move, unless you have an eligible exception ☐ Release from incarceration ☐ Return from active military service	• If the plan selection is before or on the date of the qualifying life event, the effective date is the first day of the month following the qualifying life event. • If the plan selection is after the date of the qualifying life event, the effective date is the first day of the month following the plan selection.	☐ Proof from prior carrier of MEC ☐ Proof of new residence, such as dated rental/lease agreement, deed, purchase agreement, new driver's license or state photo ID card ☐ Notice from carrier no longer providing health coverage ☐ A utility bill in the Applicant's name and containing the new address ☐ Prison release form ☐ Supporting paperwork confirming departure date from active military service
☐ Marriage. You or your spouse must have had minimum essential coverage (MEC) for one or more days during the 60 days preceding the date of marriage, unless you have an eligible exception.	First day of the month following the plan selection.	☐ Proof from prior carrier of MEC ☐ Marriage certificate

STEP 4- Continued

STEP 4 – Special Enrollment - continued		
Qualifying Life Event	**Coverage Effective Date** **Note:** The coverage effective date cannot be prior to the occurrence of the event.	**Supporting Documents**
☐ Birth ☐ Adoption ☐ Placed for adoption ☐ Placed in foster care ☐ Court order	☐ Date of qualifying life event OR ☐ The first day of the month following the plan selection	☐ Birth certificate ☐ Existing Blue Cross or Blue Plus member with proof of claims for birth ☐ Legal papers for adoption or foster care ☐ Court order
☐ Untimely notice of triggering special enrollment event	Notification can be 60 days from notice of the special enrollment event ☐ Earliest date available had the notice been timely OR ☐ The first day of the month following the plan selection	☐ Letter confirming the untimely notice of the special enrollment event
☐ A change in income, household or other status that affects eligibility for Advance Premium Tax Credit (APTC)* or Cost-sharing Reductions (CSR). Must currently be enrolled in a Qualified Health Plan.	• If the plan selection is before or on the date of the qualifying life event, the effective date is the first day of the month following the qualifying life event. • If the plan selection is after the date of the qualifying life event, the effective date is the first day of the month following the plan selection.	☐ Copy of MNsure eligibility notice
☐ MNsure or carrier determined that an unintentional enrollment error is the result of an action or omission by an agent of MNsure or Non-Exchange Entity. ☐ MNsure determined that there has been a violation of a material provision of the health plan in which you or a dependent are enrolled. Must currently be enrolled in a Qualified Health Plan.	Coverage effective date will be determined by MNsure or carrier: • You must send in the necessary supporting documentation from MNsure along with this form and a completed Application	☐ Copy of MNsure or carrier eligibility notice
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) through employer ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	Notification can be 60 days from the date the ICHRA/QSEHRA was initially offered to the individual for enrollment into an individual plan. • If the plan selection is prior to the triggering event (the first date the person's ICHRA/QSEHRA coverage can take effect), coverage must start the first of the month after the triggering event, or if the triggering event is on the first day of a month, the effective date would be the triggering event date. • If the plan selection is made on or after the triggering event, the effective date would be the first day of the month following the plan selection	☐ ICHRA/QSEHRA Form from Employer

*APTC is only available through MNsure

GO TO STEP 5

STEP 5 – Other health insurance information

Complete the information requested about your current health insurance.

1. Will you or any dependent(s) named on this Application be eligible for Medicare Part A or enrolled in Medicare Part B or both? ☐ Yes ☐ No

2. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ☐ Yes ☐ No

3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Blue Cross or Blue Plus policy. ☐ Yes ☐ No
   Note: If you have a current individual/family policy, your current policy will generally be replaced as of the effective date of your new plan unless your current coverage is through an employer or purchased through MNsure.
   If your current coverage is through an employer or another insurance carrier, Blue Cross cannot cancel that coverage for you. If you have coverage purchased through MNsure, you must contact MNsure to terminate the coverage.

4. If you answered Yes to one or more questions above, please provide the following information about any other coverage you and/or your family members currently have or have applied for:

   Name of Insurance Carrier or Governmental Plan: _____ Group Number: _____

   Name of Policyholder: _____ Effective Date: _____

   Policy Number: _____ Relationship to Applicant: _____

   Policyholder's Date of Birth: _____ Policyholder's Employment Status: _____

Effective Date of Coverage

During the Open Enrollment Period: January 1, 2025, if the Application is received on or before December 15, 2024.
February 1, 2025, if the Application is received on or between December 16, 2024 and January 15, 2025.
During the Special Enrollment Period: Your effective date is assigned by Blue Plus based on the eligibility of your selection in Step 4 - Special Enrollment and the completeness of your Application.

GO TO STEP 6

STEP 6 – Notification and authorization

By completing this enrollment Application, I understand that I will be submitting an actual request for enrollment and I agree to the following:

- My/our signature on this Application indicates that I/we have read and fully understand and agree to the following statements when applying for health coverage through Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus).
- I understand and agree that coverage, if approved, will begin as specified on page 7. I authorize Blue Plus either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Plus uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Plus receives my check and I will not receive my check back from my financial institution.
- I understand that the health plan I have selected contains a limited number of providers in the network listed on my Application, the providers in the network may change from time to time, and not every provider is in network for my plan. I also understand and acknowledge that with limited exceptions, if I visit a provider or a location that is not in network, I will pay more for my care, and these costs will count toward any applicable out-of-network cost sharing (e.g., the out-of-network deductible and out-of-pocket maximum).
- I understand that coverage will be provided under an individual contract. I understand that Blue Plus does not issue individual coverage through an employer. Blue Plus is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.
  State and/or Federal ACA compliance obligations may arise if the policy is funded in whole or in part by an employer. By submitting this application and paying the applicable premium, the applicant/payor confirms that it is in compliance with all applicable legal requirements, and that any employer funded policy is offered in compliance with applicable state and federal law such as offering such coverage through an ACA compliant ICHRA or QSEHRA arrangement.
- For purposes of obtaining information in connection with this Application, reinstatement, or change in policy benefits, this release is valid as long as I am continually covered with Blue Plus. I am entitled to receive a copy of any release I sign. I agree if I am enrolling in a product that features certain designated providers, Blue Plus may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.
- Blue Plus primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the Applicant and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the Application, even if I and/or dependent(s) listed on this Application currently have coverage or had prior coverage with Blue Plus. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota at the permanent home address listed in step 1 and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Plus will rescind my contract and coverage, and no claims will be paid. I further attest that I was not encouraged or advised to apply for this coverage in connection with any offer by an "ineligible third party" (described on page 1) to directly or indirectly pay all or some of my premiums or cost sharing.
- I understand and agree that payment of a claim does not preclude the right of Blue Plus to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid. I understand that this plan does not include coverage for the pediatric dental essential health benefit and that Blue Plus has made me aware of pediatric dental coverage available for purchase through a separate contract.
- I agree to immediately notify Blue Plus of any changes to information about me or my dependents contained in this Application. Failure to notify Blue Plus of any change in the information contained in this Application or otherwise provided may result in the denial of a claim, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- Upon request, I agree to furnish additional information about me or my dependents concerning eligibility. I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Plus will act in reliance upon the information I have provided on this Application, which materially affects enrollment eligibility and may result in the denial of a claim, rescission of the contract, the issuance of a contract amendment, or a premium adjustment.
- By providing my email address, I agree to receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Plus and its affiliates. I may unsubscribe or change my email address at any time by following the instructions included in each email communication.
- By providing my telephone number, I expressly consent to accept and receive communications and marketing materials related to the plan I selected and products offered by or made available from Blue Plus and its affiliates, via text message or voice call to my mobile device and to the cellular/mobile telephone number(s) that I provided.
  - NOTE: Email and text messaging transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. As the recipient of an email or text message from an unsecured email or device, Blue Plus does not accept liability for any errors or omissions in the contents of the email or text message, which arise as a result of email or text message transmission.
- I understand and agree that Blue Plus may share my past, current and future health and account records with my network providers about services I've received from my network providers and non-network providers. These records may be used by my network providers as needed to manage or coordinate my care and to improve the quality of that care.

GO TO STEP 7

STEP 7 – Payment and billing information

I understand that this Agreement renews on an annual basis. I acknowledge that my first payment is required by the due date printed on my first bill. I understand that failing to pay will result in my Application being voided. I understand that payments in advance of the monthly amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received. I acknowledge that if my ongoing monthly premium payments are not received within the plan grace period, my plan will be terminated. I understand that these amounts will be subject to premium increases on the date the increase is effective.

STEP 8 – Sign Application

If this Application is completed as an electronic or online Application, both parties agree to conduct this transaction electronically.

Applicant's Signature _____ Date _____

Spouse/Domestic Partner/Parent or Guardian Signature _____ Date _____

When applying for a policy that covers only a child(ren) under the age of 18, the parent or guardian must sign. The parent or guardian signing must be the same person identified on this Application as the contact person. The Applicant and spouse/domestic partner, if applicable, must sign and date this Application.

STEP 9 – Send your completed Application to Blue Plus

Send in your completed Application to Blue Plus by one of the following methods.

U.S. Mail:

Include your completed, signed Application and any applicable supporting documentation to:
Blue Plus
P.O. Box 982806
El Paso, TX 79998

Fax or email:

Fax your completed, signed Application to (651) 662-6439 or email to enrollment.forms@bluecrossmn.com

Note: Processing of your Application may be delayed if this Application is NOT completed in its entirety.
Please return all pages of the Application.

For Producer Use Only

PRODUCER ATTESTATION

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-800-262-0821.

If this section is not fully completed, you will not be assigned as the AOR.

Blue Cross Agency Code (10-digit code)	Producer Code (10-digit code)
0008905347	0003963183

A PRODUCER must complete this section to act on the Applicant's behalf.

I attest I have reviewed the completed Application with the Applicant(s) and:

- I certify that I have met the requirements listed in Minnesota Statute 60K.46 subdivision 4 regarding suitability, as well as those requirements set forth in the Agent Code of Conduct and within the Blue Cross and Blue Shield of Minnesota and Blue Plus contract. Note: Visit Agent Central and search for "Agent Code of Conduct."
- I am not aware, based on the Applicant's responses to my inquiries, of any factors impacting the eligibility of the Applicant and each of his/her dependents applying for coverage
- I further understand that no producer may accept risk or pass on any eligibility requirements, make or alter the terms of the Application or policy, or waive any contractual rights or requirements
- I attest the Applicant was present and signed this Application in my presence
- I provided a copy of the submitted Application to the Applicant(s), in its entirety, immediately in a secure manner pursuant to all applicable laws
- I agree to retain a copy of the submitted Application for my records and to provide a copy of the submitted Application to Blue Plus upon request

Agency Name King and Companies

Producer Name Sandra (FIRST) R (MI) Schlaefer (LAST)

Producer Signature Sandra Schlaefer Date

Business Telephone (952) 746-5959

BlueCross BlueShield Minnesota

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Blue Cross Blue Shield of Minnesota and Blue Plus
3400 Yankee Drive
Eagan, MN 55121

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Blue Cross Agency Code (10-digit code)	Producer Code (10-digit code)

BlueCross BlueShield Minnesota

Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota and Blue Plus, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com
Telephone: 1-800-509-5312
Mail: Blue Cross and Blue Shield of Minnesota
ATTN: Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

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ENGLISH
ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (TTY 711).

廣東話 (Cantonese – Traditional Chinese)
請注意：如果您說 廣東話 您可要求免費語言協助服務。
如果您有視力、聽力或言語障礙,
我們會以最適合您的方式與您溝通
這可能包括使用手語傳譯員、免費提供大字體或點字文件、錄音或其他輔助工具。請致電 1-855-903-2583 聽障熱線 (TTY 711)。

ESPAÑOL (Spanish)
ATENCIÓN: Si habla Español, puede solicitar servicios gratuitos de asistencia lingüística. Si tiene una deficiencia visual, auditiva o del habla, podemos comunicarnos de la manera que le resulte mejor a usted. Esto puede incluir el uso de intérpretes de lengua de señas, el suministro de documentos en letra grande o braille, grabaciones de audio u otras ayudas sin cargo. Llame al 1-855-903-2583 (TTY 711).

العربية (Arabic)
تنبيه: إذا كنت تتحدث العربية، يمكنك طلب خدمات المساعدة اللغوية المجانية. إذا كنت تعاني من إعاقة بصرية أو سمعية أو نطقية، يمكننا التواصل معك بالطريقة التي تناسبك. وقد يشمل ذلك استخدام مترجمين للغة الإشارة، أو توفير المستندات بحروف كبيرة أو بطريقة برايل، أو تسجيلات صوتية، أو غيرها من الوسائل المساعدة من دون مقابل. اتصل على الرقم 1-855-903-2583 (الهاتف النصي 711).

አማርኛ (Amharic)
ትኩረት ይሰጥ፡- አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ አገልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናገር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንገድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርጓሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጨምራል።
1-855-903-2583 (TTY 711) ላይ ይደውሉ።

FRANÇAIS (French)
ATTENTION : Si vous parlez Français, vous pouvez demander des services d'assistance linguistique gratuits. Si vous avez une déficience visuelle, auditive ou vocale, nous pouvons communiquer de la manière qui vous convient le mieux. Il peut s'agir d'interprètes en langue des signes, de documents en gros caractères ou en braille, d'enregistrements audio ou d'autres aides gratuites. Composez le 1-855-903-2583 (ATS 711).

LUS HMOOB (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, koj tuaj yeem thov cov kev pab cuam uas pab hom lus tau dawb. Yog hais tias koj qhov muag tsis pom kev zoo, tsis hnov lus, los sis hais tsis tau lus, peb tuaj yeem sib txuas lus hauv ib txoj hau kev uas ua hauj lwm tau zoo tshaj plaws rau koj. Qhov no tej zaum yuav muaj xam nrog kev siv cov neeg txhais lus piav tes, kev muab cov ntaub ntawv luam tawm ua tus ntawv loj los sis Ua Ntawv Su Rau Cov Neeg Tsis Pom Kev Siv Tau (Braille), kev kaw ua suab lus, los sis lwm yam kev pab yam tsis tau them nqi. Hu rau 1-855-903-2583 (TTY 711).

SOOMALI (Somali)
XASUUSIN: Haddii aad ku hadasho Soomali, waxaad codsan kartaa adeegyada caawimaadda luqada oo bilaash ah. Haddii aad laxaad la'aan kataahy aragga, maqalka, ama hadalka, waxaanu kugula xidhiidhi karnaa habka adiga kuugu habboon. Tan waxaa ka mid ah in aan isticmaalno turjumaanada luuqada dhegoolaha, in la bixiyo waraaqo ku qoran xarfaha waaweyn ama qoraalka indhoolayaasha, in la sameeyo cajalado la duubay, ama in la helo waxyaabo kale oo caawimaad ah oo bilaash ah. Wac 1-855-903-2583 (TTY 711).

ខ្មែរ (Khmer)
ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្តាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។

한국어 (Korean)
주의: 한국어를 사용하시는 경우 귀하는 무료 언어 지원 서비스를 요청하실 수 있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게 가장 적합한 방법으로 연락을 드릴 수 있습니다. 여기에는 수화통역사 이용, 대형 활자 또는 점자로 작성된 문서 제공, 음성 녹음 또는 기타 무료 지원이 포함될 수 있습니다.
1-855-903-2583 (TTY 711)번으로 전화하십시오.

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ကညီကျိာ် (Karen) ဟ်သူဉ်ဟ်သး- နမ့်၊ကတိၤ ကညီကျိာ် နှဉ်, နဃ့ကျိာ်ဂ့်၊ဝီတ၊်တိစၢၤမၤစၢၤလၢတလၫ်ဘူးလဲ သ့နှဉ်လီၤ. နမ့်၊အိဉ်ဒီးတ၊်တလၢတပှဲၤလၢ မဲာ်တ၊်ထံဉ်, တ၊်နှ၊်ဟူ, မ့တမ့်၊ တ၊်စံးကတိၤတ၊်နှဉ် ပဆဲးကျၢဆဲးကျိးတ၊်လၢ ကျဲကဲထိဉ်လိာ်ထိဉ်အဂ့ၤကတ၊်လၢနဂီ၊်သ့နှဉ်လီၤ. တ၊်အံၤပဉ်ဃုာ်ဒီး တ၊်စူးကါ နီ၊်ခိက့၊်ဂီၤကျိာ်အပှၤကျိာ်ထံတ၊်တဖဉ်, တ၊်ဟ့ဉ်လံာ်လ၊်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့်၊ ပှၤမဲာ်ဘျိဉ်အလံာ်, တ၊်ကလုာ်, မ့တမ့်၊ တ၊်မၤစၢၤဂုၤဂၤတဖဉ် လၢတလၫ်အဘူးလဲနှဉ်လီၤ. ကိးလီတဲစိဆူ 1-855-903-2583 (TTY 711) တက့၊်.	**မြန်မာဘာသာ (Burmese)** သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊ အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို တောင်းဆိုနိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ သို့မဟုတ် စကားပြောခြင်း ချို့ယွင်းမှုရှိနေပါက သင့်အတွက် အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့် ကွန်ပ်တို့ထံသို့ ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပြဘာသာစကား စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မြင်စာဖြင့် ပံ့ပိုးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။
OROMOO (Oromo) Xiyyeeffannoon haa kennamuː- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.	**РУССКИЙ (Russian)** ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).
ພາສາລາວ (Lao) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື, ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ 1-855-903-2583 (TTY 711).	**Tagalog (Tagalog)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).
VIETNAMESE (Vietnamese) LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).	简体中文 **(Chinese Simplified)** 注意：如果您说普通话，则可以免费申请语言协助服务。如果您有视力、听力或语言障碍，我们可以用最适合您的方式与您交流。这可能包括免费提供手语翻译、大字体或盲文文件、录音或其 他辅助工具。 请致电 1-855-903-2583（文字电话 711）。

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