BlueCross BlueShield of Minnesota

DOW-R Dental Insurance

DOW-R Usage Loc#______
Enrolled online in ☐ BCBS ☐ Dental
Effective Date__________________________
Single 1000/1500 Family 1000/1500
Single 5000 Family 5000
Waived Cancel
Previously Waived COBRA E S
Hire Date _______ #Hrs Wrkd ___

ENROLLMENT/CHANGE/WAIVE GROUP COVERAGE FORM A-1 FOR 9/1/19 – 8/31/20 PLAN YEAR

- **If waiving coverage, complete sections I and II**
- **If open enrollment and keeping same coverage, do nothing**
- **If enrolling or changing coverage, complete entire form except for Section II**

I. Employee Information – must be completed for both enrollees and waivers **Group: Diocese of Winona-Rochester**

Last Name	First Name	MI	Social Security Number

Address

City	State	Zip	Home/Cell Telephone

Work E-mail address	

Summary of Benefits and Coverage – BlueCross BlueShield of Minnesota

A Summary of Benefits and Coverage (SBC) is available for medical plans only to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by contacting your employer or your employer's Agent or Broker, or by calling Customer Services at 1-800-382-2000 toll free.

II. Waiver of Coverage - Complete this section ONLY if you are declining coverage for you and /or your family members

I hereby acknowledge that I have been given the opportunity to participate in the group medical and dental plans provided by my employer. If I and/or any of eligible dependents desire to apply for this coverage at a later date, I may be required to wait until my group's renewal or until a special enrollment even occurs before coverage will be offered.

During open enrollment only - If you had coverage during August 2019 and are now waiving it, you are terminating/cancelling that coverage for you and your dependents effective 9/1/2019.

Special Enrollment Rights:
If you are declining enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order, you may be able to enroll yourself and your eligible dependents. In order to avoid claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Special enrollment may also be available as a result of a marriage, provided that you request enrollment within 30 days after the marriage.

______________________________________ ______________________
Employee/Contractholder Signature - **Only Sign Here If You Are Waiving Coverage** Date

III. Benefit Selection – Check Appropriate Boxes to Add or change Coverage

Coverage Selected: ☐ Single ☐ Family	Coverage Level: ☐ $1000 Deductible 9/1/19 then $1500 on 1/1/20 ☐ $5000 Deductible

IV. Self & Dependent Information (If enrolling more than four dependents, please attach a separate sheet.) If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

Effective Date	

Relation	*Last Name*	*First Name*	*MI*	*Add/ Cancel*	*Gender*	*Marital Status*	*Social Security Number*	*Date of Birth (mm/dd/yyyy)*
Self				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Spouse				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		

Continued on next page

Relation	Last Name	First Name	MI	Add/ Cancel	Gender	Marital Status	Social Security Number	Date of Birth (mm/dd/yyyy)
Child/ Stepchild				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child/ Stepchild				☐Add ☐Cancel	☐Male ☐Female	☐Single ☐Married		
Child Age 26 or older and Disabled				☐Add ☒Cancel	☐Male ☐Female	☐Single ☐Married		

Additional family members on attached page

V. Other Health (Medical) Insurance Coverage

A. Other Group or Non-Group Health (Medical) Insurance Coverage – only if continuing coverage with this group/non-group

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder

Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status: ☐ Active or ☐ Retired Date of Retirement / /

B. Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health (Medical) Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								☐Yes ☐ No
								☐Yes ☐No
								☐Yes ☐No

VI. Important: Authorized Signature Required if Taking or Cancelling Insurance

Read this section, sign and date the Application. Blue Cross and Blue Shield of Minnesota and/or Blue Plus hereinafter referred to as The Company, will act in reliance on the information you provide on this Application.

For the purposes of the Application, I understand and agree that ‘employee’ is defined as only those individuals subject to FICA and other tax withholding, and performing services for compensation for the employer listed in Section I of this Application.

In order to process this Application, The Company may collect personal information regarding me or my family members listed on this Application. The information collected by The Company or The Company’s authorized agents may in certain circumstances be disclosed to third parties without authorization. I have the right to see my personal records that are maintained by The Company and to correct personal information The Company has collected about me or my family members listed on this Application. Upon my request, The Company will furnish a more detailed notice of The Company information practices. The Company keeps this information confidential, but may release it if I authorize release, or if state or federal law permits or requires release without authorization. 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 insured with the insurer. 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, The Company 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’ve 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.

The Company primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept me and my family members listed on this Application for coverage. I acknowledge the importance of providing accurate

and complete information. I acknowledge I must answer all required questions in the Application, even if I and/or my family members listed on this Application currently have coverage or had prior coverage with The Company.

I understand and agree that payment of a claim does not preclude the right of The Company 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 neither the medical plan nor the dental plan includes coverage for the pediatric dental essential health benefit and that The Company has made me aware of pediatric dental coverage available for purchase. For additional information on available pediatric dental plans, please visit www.mnsure.org.

I agree to notify The Company immediately of any change in my or my family member's enrollment information between the date of this Application and the effective date of coverage. Failure to notify The Company of any change in the information contained on this Application may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

Upon request, I agree to furnish any additional information needed concerning the eligibility of any family member applying for coverage. The Company 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 The Company is not required by law to accept such third-party payments. This may include, for example, commercial entities, healthcare 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 fund transfer, etc. If you have questions about this third party payment policy or whether The Company will accept premium and/ or cost-sharing payments made by a specific person or entity, please contact your employer.

I acknowledge that I am not applying for this coverage in connection with any offer from any ineligible third-party to pay any premium or cost-sharing related to this plan.

I understand that the health plan I have selected may contain 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 towards any applicable Out-of-Network cost sharing (e.g., the Out-of-Network deductible and Out-of-Pocket [Limitation / Maximum]).

By providing your email address, you agree to receive communications and/or marketing materials related to the Plan you selected and products offered by or made available from The Company and its affiliates. You may unsubscribe or change your email address at any time by following the instructions included in each email communication.

By providing your phone number, you expressly consent to accept and receive communications and /or marketing materials related to the Plan you selected and products offered by or made available from The Company and its affiliates, via text message or voice call to your mobile device and to the cellular/mobile telephone number(s) that you provided to us.

WARNING: E-mail 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, The Company, does not accept liability for any errors or omissions in the contents of this message, which arise as a result of e-mail or text message transmission.

AUTHORIZATION OF COVERAGE: My signature authorizes any payroll deduction required to participate in the plan.

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 The Company will act in reliance upon the information I have provided on this Application and that any false information, omissions or misstatements on this Application which materially affect enrollment eligibility may result in the denial of a claim(s), rescission of the contract and/or a premium adjustment.

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

______________________________	______________________________
Print Employee Name	Date
______________________________	Group: Diocese of Winona-Rochester
Employee Signature	

Please contact your employer or email benefits@dowr.org or call 507-858-1268.
This information is available in other ways for people with disabilities who need it translated into another language by calling 1-800-382-2000 (toll free). For TTY, call 711. Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

Submission Instructions

Employees: Please return your completed form to your employer. This form is used to enroll you in DOW-R dental insurance.
Employers: Completed employee forms should be uploaded to Dropbox ☐Uploaded to Dropbox