BlueCross BlueShield of Minnesota

DOW-R Dental Insurance

DOW-R Usage Loc#_____

Effective Date_____
Single 1500 Family 1500
Single 5000 Family 5000
Waived Cancel
Previously Waived
Date to BCBS _____
Date to DD _____

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

- **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: ☐ $1500 Deductible 1/1/20
☐ $5000 Deductible

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		