



An independent licensee of the Blue Cross & Blue Shield Association

DCN

Health Benefit Plan Affiliation and Out-of-Area Waiver Form

(Please type or print in black ink)

Section 1 - Affiliation:

Please indicate the Network name and Network number you have chosen for you and your Eligible Dependents.

Network Name _____

Section 2 - Out-of-Area Waiver:

Eligible Dependent children of the Subscriber or of the Subscriber's living, covered spouse are eligible for this waiver if:

- They reside at a facility for children with disabilities or other special needs (Anne Carlson School, etc.);
- They reside outside the Network Service Area and you or your living, covered spouse are required by court order to provide health coverage for them; or
- They are full-time students who reside outside the Network Service Area who are financially dependent on you or your living, covered spouse.

I certify my Eligible Dependent children listed below meet at least one of the above requirements. I understand all Covered Services received will be reimbursed at the In-Network benefit level.

Child's Name/Address	Birth Date (mm-dd-yy)	Resides at a special needs facility	Covered by court order and residing out of area	Financially dependent full-time student residing out of area
_____	__-__-__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	__-__-__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	__-__-__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	__-__-__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I understand my Eligible Dependents and I must receive care within the Network I have selected, with the exception of Eligible Dependent children listed in **Section 2 - Out-of-Area Waiver**. Use of providers outside my Network will result in a reduction of benefits, unless an Authorized Referral has been obtained or the Out-of-Area Waiver is in effect.

Requested Effective Date: _____

Employer Name: _____

Employee Name: Last _____ First _____ M.I. _____

Employee Benefit Plan Number: _____

Employee Work Phone Number: () - _____ Home Phone Number: () - _____

Employee's Signature: _____ Date: _____

Spouse's Signature (if to be insured): _____ Date: _____

Send completed form to: Blue Cross Blue Shield of North Dakota, Underwriting Department
4510 13th Avenue S., Fargo, ND 58121