



**BlueCross
BlueShield**
of North Dakota

An independent licensee of the
Blue Cross & Blue Shield Association

DCN

**North Dakota Public Employees Retirement
System (NDPERS) Group Health Application**



29301733 Rev. 6-09

Please type or print in black ink. Press firmly.

BPN _____

1. PAYROLL TO COMPLETE THIS SECTION.

GROUP ROLL _____

Department Number	Initial	Agency Name	Permanent Employment Date (mm-dd-yy)

2. APPLICANT'S INFORMATION

Last Name	First	M.I.	Social Security Number
Mailing Address			State in Which You Reside
City	State	Zip Code	Home Phone () -
			Work Phone () -
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced (Give date if changing Marital Status)	Sex	Birth Date (mm-dd-yy)
<input type="checkbox"/> Married <input type="checkbox"/> Widowed		<input type="checkbox"/> M <input type="checkbox"/> F	
			Active in the Military? <input type="checkbox"/> Yes <input type="checkbox"/> No

3. COVERAGE INFORMATION

I am applying for:	HEALTH (BCBSND) coverage:
<input type="checkbox"/> Single Coverage = myself only	<input type="checkbox"/> New Coverage (I do not have BCBSND coverage now)
<input type="checkbox"/> Family Coverage = myself and spouse OR myself and eligible children OR myself, spouse and eligible children	<input type="checkbox"/> Transfer from NDPERS or any other coverage (If yes, complete Section 5.)
<input type="checkbox"/> Covered under spouse's NDPERS Benefit Plan Number _____	<input type="checkbox"/> COBRA/State Continuation
Effective Date	Change in Dependents:
	<input type="checkbox"/> Add <input type="checkbox"/> Remove Date Change Occurred - -
	NOTE: You must complete Section 4 for all family members to be covered if adding or removing dependents.

4. SPOUSE/DEPENDENT INFORMATION (Use extra paper if necessary)

- List all family members to be covered, other than yourself. Indicate their relationship to you, i.e. spouse, child, stepchild, etc.
- Indicate dependent's address below dependent's name **if the address is different from yours.**
- If Marital Status is Single and you are applying for coverage for your Eligible Dependent(s), you are required to attach a copy of the state birth certificate for each dependent unless previously submitted.**

First Name	M.I.	Last (if different)	Relationship	Sex	Birth Date (mm-dd-yy)	Active Military	Full-Time Student	Court Ordered Coverage	Social Security Number
			SPOUSE	<input type="checkbox"/> M <input type="checkbox"/> F	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A	- -
				<input type="checkbox"/> M <input type="checkbox"/> F	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -
				<input type="checkbox"/> M <input type="checkbox"/> F	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -
				<input type="checkbox"/> M <input type="checkbox"/> F	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	- -

5. OTHER COVERAGE INFORMATION (Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. Failure to provide documentation may affect your waiting period.)

Other Health Benefit Plan including BCBSND coverage/Publicly Sponsored Program

Yes No Are you, your spouse or any of your Eligible Dependents currently or previously covered by another health benefit plan(s)? If yes, please complete this section.

Other Coverage Name	Other Coverage Phone Number	Policy Number	Policyholder (first, m.i., last name)	Birth Date (mm-dd-yy)
Policy Coverage Dates (mm-dd-yy) From - - to - -		Name(s) of Person(s) Covered		

Yes No Do you intend to keep your current policy in force after the effective date of this application? If not, why? _____

Workers' Compensation/No-Fault

Yes No Are you, your spouse or any of your Eligible Dependents currently receiving or have received workers' compensation benefits?

Yes No Are you, your spouse or any of your Eligible Dependents currently receiving or have received no-fault benefits?

Person's Name	Injury Date (mm-dd-yy)	Type of Injury	Company Providing Benefits/ Phone Number

6. SIGNATURE (This form must be signed and dated)

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plan(s) issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X _____
Applicant's Signature Date Signed

Yes I am applying for coverage during Annual Open Enrollment.

LIMITATIONS AND EXCLUSIONS

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

CONVERSION RIGHTS FOR HEALTH COVERAGE

In the event the group through which I am enrolled elects to terminate, Blue Cross Blue Shield of North Dakota has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.

Conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with Blue Cross Blue Shield of North Dakota and has enrolled as a group with another insurance carrier.

METHOD OF PAYMENT

In the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit the same to Blue Cross Blue Shield of North Dakota. This authorization is to continue in effect until revoked by me in writing.

If you require accommodation or assistance in completing this form or require this form in a different format please call the NDPERS ADA Coordinator at 701-328-3900 or 1-800-803-7377 if you are outside the Bismarck/Mandan local calling area.

