

# Individual Membership Application



**BlueCross BlueShield**  
of North Dakota

*An independent licensee of the Blue Cross & Blue Shield Association*

4510 13th Avenue South  
Fargo, North Dakota 58121-0001

DCN

29300945

Rev. 1-06

BPN \_\_\_\_\_

## Individual Membership Application

*Please type or print in black ink. Press firmly.*

**GROUP ROLL**

### 1. APPLICANT'S INFORMATION

Last Name	First	M.I.	Social Security Number
Mailing Address			Home Phone ( ) -
City	State	Zip Code	Work Phone ( ) -
<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	(Give date if changing Marital Status) - -	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Birth Date</b> (mm-dd-yy) - -
<b>Requested Effective Date</b> (mm-dd-yy) - -	Applicant's Employer	Occupation	
		<b>Height</b> _____ ft _____ in	<b>Weight (lbs)</b> _____

### 2. 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. 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)	Height (ft & in)	Weight (lbs)	Active Military	Full-Time Student	Court Ordered Coverage	Social Security Number
			<b>SPOUSE</b>	<input type="checkbox"/> M <input type="checkbox"/> F	- -			<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>N/A</b>	<b>N/A</b>	- -
Address:				<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	- -
Address:				<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	- -
Address:				<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	- -
Address:				<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	- -

### 3. COVERAGE INFORMATION

- Yes  No Will any portion of the premium be paid by your employer or your spouse's employer, either directly or through wage adjustments or other means of reimbursement?
- Yes  No Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code? (See back page "Coverage Information" for additional explanation.)

**HEALTH coverage:**

- New Coverage (I do not have BCBSND coverage now)  
 Change in Existing BCBSND Coverage

**I am applying for:**

- Single Coverage = myself only  
*If married, is your spouse covered by an employer sponsored group health benefit plan?  Yes  No If no, must apply for Family Coverage.*
- Single Plus Dependent Coverage = myself and eligible children  
*If married, is your spouse covered by an employer sponsored group health benefit plan?  Yes  No If no, must apply for Family Coverage.*
- Family Coverage = myself and spouse **OR** myself, spouse and eligible children

**DEPOSITOR \*(you must complete section 3A)**

**Deductible**

- Comprehensive Major Medical\* ..... \$ \_\_\_\_\_
- Personal Choice\* ..... \$ \_\_\_\_\_
- Blue Saver 80\* ..... \$ \_\_\_\_\_
- Blue Saver 100\* ..... \$ \_\_\_\_\_  
 (see back page "Blue Saver Plan" for additional explanation)
- Personal Choice for Students ..... \$ \_\_\_\_\_  
 (see back page "Eligibility Requirements for Personal Choice for Students")
- Standard Plan ..... \$ \_\_\_\_\_
- Basic Plan ..... \$ \_\_\_\_\_
- Conversion ..... \$ \_\_\_\_\_
- Basic Conversion ..... \$ \_\_\_\_\_

### 3A. Automatic Payment Withdrawal (Include Voided Check)

Payment for all coverage may be made by automatic payment withdrawal; however, **automatic payment withdrawal is mandatory for coverage indicated under the Depositor category.**

Name of Financial Institution \_\_\_\_\_

City \_\_\_\_\_

Account Number \_\_\_\_\_

- Checking Account       Savings Account

*I hereby authorize my financial institution to deduct the current premium from my checking or savings account and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing. A 31-day notice is needed when cancelling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in my account.*

Signature \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

**4. 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 and Phone Number	Policy Number	Policyholder (first, m.i., last name)	Birth Date (mm-dd-yy) - -
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Policy Coverage Dates (mm-dd-yy) From - - to - -	Name(s) of Person(s) Covered
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Yes  No Does this coverage provide maternity benefits?  
 Yes  No Do you intend to keep your current policy in force after the effective date of this application? **If not, why?**

**Medicare**

Yes  No Are you, your spouse or any of your Eligible Dependents currently or previously covered by Medicare? If yes, please complete this section.

Name(s) of Person(s) Covered by Medicare	Medicare ID Card Number(s) (include alpha characters)
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Hospital Part A Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> 01- <input type="checkbox"/> <input type="checkbox"/>	Medical Part B Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> 01- <input type="checkbox"/> <input type="checkbox"/>	Prescription Drug Part D Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> 01- <input type="checkbox"/> <input type="checkbox"/>
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**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
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**5. HEALTH INFORMATION - Explain any "yes" answers below.**

Has any person named on this application ever had, been treated or diagnosed for:

- |  |   |
|--|---|
| <p><b>Yes No</b></p> <ol style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Anemia, leukemia or any blood disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Any disability, injury or bodily deformity</li> <li><input type="checkbox"/> <input type="checkbox"/> Any physical impairment or condition requiring periodic or long-term follow-up such as cerebral palsy, multiple sclerosis, muscular dystrophy, etc.</li> <li><input type="checkbox"/> <input type="checkbox"/> Arthritis or rheumatism</li> <li><input type="checkbox"/> <input type="checkbox"/> Asthma, emphysema, COPD, any lung disease, sleep apnea or use of a CPAP machine</li> <li><input type="checkbox"/> <input type="checkbox"/> Cancer, tumor or any abnormal growth (malignant or non-malignant)</li> <li><input type="checkbox"/> <input type="checkbox"/> Diabetes or sugar in urine. <b>If yes, a current Hgb A1C level from a medical professional is required. State name of insulin below.</b></li> <li><input type="checkbox"/> <input type="checkbox"/> Seizures, epilepsy, loss of consciousness or fainting spells</li> <li><input type="checkbox"/> <input type="checkbox"/> Goiter or thyroid disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Hernia, hemorrhoids or varicose veins</li> <li><input type="checkbox"/> <input type="checkbox"/> Heart attack, angina or other heart disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Stroke, paralysis or circulatory disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Hypertension or high blood pressure. <b>If yes, a current blood pressure reading from a medical professional is required.</b></li> <li><input type="checkbox"/> <input type="checkbox"/> Liver or gallbladder disorder, jaundice or gallstones</li> <li><input type="checkbox"/> <input type="checkbox"/> Kidney stone, kidney, bladder or prostate disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Endometriosis, fibroids, prolapse, abnormal female bleeding, menstrual disorder or abnormal pap smear</li> <li><input type="checkbox"/> <input type="checkbox"/> Infertility (male or female)</li> </ol> | <p><b>Yes No</b></p> <ol style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Psychiatric, nervous or mental disorder, depression, recurrent headaches, migraine or attention deficit disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Chemical dependency or alcoholism or been treated for the use of alcohol or drugs</li> <li><input type="checkbox"/> <input type="checkbox"/> Ulcers, ulcerative colitis, Crohn's disease, stomach or intestinal disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Back disorders, chronic low back pain or disk disorders</li> <li><input type="checkbox"/> <input type="checkbox"/> Cataract, visual loss, ear infection or ear disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Temporomandibular or Craniomandibular Joint Treatment (TMJ or CMJ)</li> <li><input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)</li> <li><input type="checkbox"/> <input type="checkbox"/> <b>Any other condition, disorder, illness or disease</b> for which further diagnostic tests, consultation, observation, treatment, surgery or hospitalization has been recommended</li> <li><input type="checkbox"/> <input type="checkbox"/> Have you or any of your Eligible Dependents been treated by a chiropractor in the last year? <b>If yes, state frequency of treatments and date of last treatment below.</b></li> <li><input type="checkbox"/> <input type="checkbox"/> Are you or any of your Eligible Dependents taking medicine prescribed by a physician? <b>If yes, list person(s) and medication(s) below.</b></li> <li><input type="checkbox"/> <input type="checkbox"/> Are you or any of your Eligible Dependents pregnant? (Indicate even if spouse/dependents are not applying)</li> <li><input type="checkbox"/> <input type="checkbox"/> Are you or any of your Eligible Dependents currently a resident in a custodial center or nursing home?</li> <li><input type="checkbox"/> <input type="checkbox"/> Has any person named in this application been ill, injured or consulted with a health care provider <b>for any other reason within the past five years?</b></li> </ol> |
|--|---|

**Explain "yes" answers to any of the above questions. Give complete details. Also indicate the patient's current physician. Use extra paper if necessary.**

Question Number	Patient First Name	Diagnosis, Treatment or Reason for Medical Attention	Attending Physician Name and Address	Current Physician Name and Address	Date of Onset	Days in Hospital	Recovery Date	Workers' Comp. (Y/N)	No-Fault (Y/N)

**6. SIGNATURE(S) (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 \_\_\_\_\_ X \_\_\_\_\_  
**Applicant's Signature** **Date Signed** **Spouse's Signature (if to be insured)** **Date Signed**

<b>Agent Number</b>	<b>Agent Name</b>	<b>Date App Received</b> - -	<b>Amount Received with App</b> \$ _____ . _____	<b>Voucher Number</b>
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### COVERAGE INFORMATION

I understand if I pay any portion of my health insurance premiums using pretax dollars (Section 125) or my employer pays any portion of my health insurance premiums (Section 106) or provides reimbursement for uninsured medical expenses for me and my dependents (Section 162), I should answer "yes" to the question, "Do you, your employer or any of your Eligible Dependents intend to treat this health Benefit Plan as part of a plan or program under Section 162, Section 125 or Section 106 of the U.S. Internal Revenue Code?" (located in Section 3, Coverage Information).

### BLUE SAVER PLAN

I understand the Blue Saver Benefit Plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account. I also understand BCBSND does not provide tax, investment or legal advice. If I have questions about a Health Savings Account or the tax implications of the Blue Saver Benefit Plan, I should contact a qualified tax, investment or legal professional.

### ELIGIBILITY REQUIREMENTS FOR PERSONAL CHOICE FOR STUDENTS

To be eligible for coverage under this Benefit Plan, the applicant must currently be and continue attending an accredited educational elementary, secondary or post-secondary institution in North Dakota, or must be a resident of the state of North Dakota attending school full-time or must be younger than school age and not eligible for coverage under any other available Benefit Plan. The Subscriber under this Benefit Plan becomes ineligible for coverage if that Subscriber does not remain enrolled in school on a continuous basis during any two consecutive school terms, including summer sessions. Coverage under the terms of this Benefit Plan terminates automatically when the Subscriber ceases attending school and does not continue to pursue their education.

### LIMITATIONS AND EXCLUSIONS

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

Benefits are **not** available for any services, supplies or charges for the care or treatment received by me or any of my Eligible Dependents listed on this application for 365 days following the individual Member's effective date of coverage under the Benefit Plan for a condition, disease, illness or injury for which medical advice or treatment was received within the six-month period immediately preceding the individual Member's effective date of coverage under the Benefit Plan.

Benefits are **not** available for services received by me or any of my Eligible Dependents listed on this membership application for services received during the 365-day waiting period, beginning on the effective date of the individual Member's coverage for human organ and tissue transplants, tonsillectomies, adenoidectomies, typanostomies requiring the insertion of ventilating tubes, myringotomy without ventilating tubes, excision of cataracts, hysterectomies, sterilization procedures\*, treatment of hernias, treatment of hemorrhoids, breast reduction surgery, surgical treatment of morbid obesity\*\*, maternity delivery services (except for complications of pregnancy)\*\*\*, postnatal care or the surgical treatment of gallbladder and the bile duct system.

The waiting period may be reduced by Qualifying Previous Coverage, if continuous until at least 63 days prior to the individual Member's effective date of coverage under the Benefit Plan.

\* **No coverage is available for sterilization procedures under the Basic Plan or Basic Conversion.**

\*\* **No coverage is available for the treatment of morbid obesity under Personal Choice, Standard Plan, Basic Plan or Basic Conversion.**

\*\*\* **No coverage is available for maternity services under Personal Choice. Benefits will be available for services provided to treat complications caused by pregnancy.**

No coverage is available for infertility services under Personal Choice, Standard Plan, Basic Plan or Basic Conversion.

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## BLUE CROSS BLUE SHIELD OF NORTH DAKOTA OFFICES

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**If you have questions or require assistance when completing this application,  
please contact one of our offices listed below:**

**Home Office**  
4510 - 13th Ave. S.  
Fargo, North Dakota 58121-0001  
Telephone (701) 277-2227

**Fargo District Office**  
4510 - 13th Ave. S.  
Telephone 282-1149

**Bismarck District Office**  
Tuscany Square - 107 W. Main  
Telephone 223-6348

**Grand Forks District Office**  
American Office Park - 2810 19th Ave. S.  
Telephone 795-5340

**Minot District Office**  
1600 S. Broadway  
Telephone 858-5000

**Jamestown Office**  
300 2nd Ave. NE. Suite 132  
Telephone 251-3180

**Dickinson Office**  
150 W. Villard - Suite 2  
Telephone 225-8092

**Devils Lake Office**  
425 College Dr. S. - Suite 13  
Telephone 662-8613

**Williston Office**  
1137 2nd Ave. W. - Suite 105  
Telephone 572-4535

