BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

Assurant Life Assurant Dental

A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM – INSTRUCTIONS FOR CHANGES ON PAGE 2

Employee's Last name | First name | M.I. | Social Security Number | Home phone ( )

Employee's Home address | Street | City | State | Zip code | Work phone ( )

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED – COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (Circle)	Last name	First name	M.I.	Add/ Cancel	Sex (Circle)	Marital status	Social Security #	Birth Date (Mo. Day Yr.)	Primary Care Clinic #	Full-time Student
Self				E Add E	M / F	E Married E Single				E Yes E No
Spouse				E Add E	M / F	E Married E Single				E Yes E No
Child Stepchild				E Add E	M F /	E Married E Single				E Yes E No
Child Stepchild				E Add E	M F /	E Married E Single				E Yes E No
Child Stepchild				E Add E	M F /	E Married E Single				E Yes E No

For full-time student list school: Anticipated graduation date:

C. BENEFIT SELECTION – CHECK APPROPRIATE BOXES TO ELECT OR WAIVE COVERAGE

- O Elect or O Waive Health (self) _____
- O Elect or O Waive Health (dependents)
- O Elect or O Waive Dental (self)
- O Elect or O Waive Dental (dependents)
- O Elect or O Waive Supplemental Life (Benefit chosen $ _____)
- O Elect or O Waive STD
- O Elect or O Waive Life/AD&D (self)
- O Elect or O Waive Life/AD&D (dependents)
- O Elect or O Waive LTD

Health plan product name:

Dental plan product name:

If applying for life benefits, please indicate Beneficiary name and Relation to self:

Primary Beneficiary name _____ Relation to self

Contingent Beneficiary name

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X Signature of employee Month Day Year Date signed

D. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):

Employee occupation:

Hours worked per week:

Monthly salary (Complete only if applying for salary based benefits) $

Indicate the reason employee is enrolling for coverage:

- O New employee
- O Rehire (length of layoff)
- O New group
- O Return from leave of absence (length of absence)
- O Previously waived coverage
- O Change from part-time to full-time
- O Certificate of coverage termination
- O Other

Date of event:

Group numbers:

Health | Dental | Life | STD | LTD

Department number | Class

I certify the above information to be true and correct.

Signature _____ Date _____

Employer name | Telephone number | Fax number