BlueCross BlueShield of Minnesota

DELTA DENTAL

Loc # _____

QUALIFYING EVENT FORM FOR GROUP COVERAGE

A. EMPLOYEE INFORMATION

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) Add/Cancel Effective Date:_____

Relation	Last Name	First Name	M.I	Add / Cancel Effective Date	Sex	Marital Status	Social Security #	Birth Date (Mo.Day Yr.)		
Self				☐Add ☐Cancel Eff Date_____	☐M ☐F	☐Single ☐Married				
Spouse				☐Add ☐Cancel Eff Date_____	☐M ☐F	☐Single ☐Married				
Child/ Stepchild				☐Add ☐Cancel Eff Date_____	☐M ☐F	☐Single ☐Married				
Child/ Stepchild				☐Add ☐Cancel Eff Date_____	☐M ☐F	☐Single ☐Married				
Child/ Stepchild				☐Add ☐Cancel Eff Date_____	☐M ☐F	☐Single ☐Married				

C. BENEFIT SELECTION - CHECK APPROPRIATE BOXES TO ELECT COVERAGE

Coverage Selected: Coverage Level:

Medical: ☐ Single ☐ Family ☐ $1000 Deductible ☐ $6350 Deductible

D. CURRENT AND PREVIOUS COVERAGE – Failure to fully complete this section may result in a pre-existing condition limitation. Please attach copies of all certificates of prior coverage.

Do you or any family member listed on this application, have any current health coverage or had previous health coverage within the last 63 days? ☐ Yes ☐ No If *YES* you must fully complete the following Section

If you or any family member applying for this coverage is currently covered by Blue Cross and Blue Shield of Minnesota, Blue Plus, or Delta Dental, do you want that coverage canceled? ☐Yes ☐No

If YES, provide the individual's name, identification number, group number and cancellation date:

Starting with the employee, list each family member applying for our coverage and include information for all current and previous coverage in effect during the last 18 months. Make sure to include information for other Blue Cross and BlueShield of Minnesota coverage:

Family Member Name	Insurance Company (name and policy number)	Date Coverage Started	Date Coverage Ended	Reason for Termination

E. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? Yes (complete section below)

Employee:

Effective Date Part A ___ ___ ___ Effective Date Part B ___ ___ ___ Medicare Claim Number _____

Eligibility reason for Medicare: ☐Age ☐Disability ☐End-Stage Renal Disease ☐Disability & End-Stage Renal Disease

Spouse:

Effective Date Part A ___ ___ ___ Effective Date Part B ___ ___ ___ Medicare Claim Number _____

Eligibility reason for Medicare: ☐Age ☐Disability ☐End-Stage Renal Disease ☐Disability & End-Stage Renal Disease

F. COVERAGE CHANGE INFORMATION - CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B, C and G

Adding dependents: Date of event

- ☐ Birth/adoption _____
- ☐ Court order _____
- ☐ Marriage _____ County _____ Details _____
- ☐ Other _____

Cancelling dependents: Date of event

- ☐ Divorce _____
- ☐ Other (please explain) _____

- ☐ Loss of prior health and/or dental coverage:

  Did you lose health coverage, dental coverage or both? _____

  Date of event

- ☐ Other coverage voluntarily terminated _____
- ☐ Group continuation (COBRA) period exhausted _____
- ☐ Employer contribution for coverage terminated _____
- ☐ Coverage terminated due to loss of eligibility _____ Reason _____

- ☐ Address change
- ☐ Primary care clinic change
- ☐ Phone number change
- ☐ Name change

  Previous _____

  List new name is Section A

G. SIGNATURE

AUTHORIZATION OF COVERAGE

MY SIGNATURE AUTHORIZES ANY PAYROLL DEDUCTION REQUIRED TO PARTICIPATE IN THE PLAN. I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X	Month	Date	Year

Signature of Employee **Date Signed**

WAIVER OF COVERAGE

I HAVE BEEN INFORMED THAT I AM ELIGIBLE TO ENROLL FOR COVERAGE THROUGH MY EMPLOYER. I DO NOT WANT COVERAGE.

X	Month	Date	

Signature of Employee **Date Signed**

H. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:

Indicate the reason employee is enrolling for coverage:

☐ Qualifying Event Date of Event _____

Group Numbers:

Health _____ Dental _____

Department Number _____

I certify the above information to be true and correct.

Signature _____ Date _____

Employer Name	Telephone number	Fax number
Diocese of Winona	(507) 858-1268	(507) 454-8106

ENROLLMENT / CHANGE FORMS SHOULD BE SENT TO:

Diocese of Winona
PO Box 588 OR Fax: OR E-mail:
Winona, MN 55987 (507)454-8106 benefits@dow.org

Questions? Contact the Employee Benefits Coordinator at (507)858-1268 or benefits@dow.org