BlueCross BlueShield of Montana

Applicant Name: _____

Social Security Number (SSN): _____

Member ID: _____

Internal Use Only

Sign Up for a **2021 Health Plan** for You and Your Family.

You can visit **www.bcbsmt.com** to sign up. If you are working with a Blue Cross and Blue Shield of Montana (BCBSMT) agent, be sure to include your independent, authorized agent's information on the final page.

TO HELP US PROCESS YOUR APPLICATION MORE QUICKLY, BE SURE TO:

- Answer **all** questions that apply to you. Include name and SSN at the top of all 14 pages. Submit all 14 pages, even pages you don't use.
- Page 2 is only for a Special Enrollment Period (SEP). Check if you qualify for an SEP before filling out this Application for SEP.
- Answer **all** questions about legal dependents you are signing up.
- Include the **first month's payment** or payment details on Page 10.
- Include details for how you want to make monthly payments.
- Sign the Application everywhere a signature is required.
- Print all answers in **black ink**. Pencil will not be accepted.
- **If you need to change an answer,** cross out what you are changing and add your initials by the new answer. Do not use correction fluid or tape.
- **To receive language or communication assistance free of charge, call 855-710-6984.**

WHAT DO YOU WANT TO DO?

☐ Become a **NEW** BCBSMT member.

☐ **CHANGE** my 2021 BCBSMT health plan.

☐ **ADD** a dependent to my current BCBSMT health plan.[1]

HOW MAY WE CONTACT YOU?

If you want to get information from us electronically, we **must** have your email address. **By listing an email address, you agree we may send your policy information electronically.** This electronic delivery will continue through any policy renewals or changes.

You can go back to paper delivery at any time with no penalty. To make or change your choices once you are a member, you may:

- Go digital. Update your preferences and contact information at **www.bcbsmt.com/preferences** or text[2] CONTACTMT to 33633.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Internet Explorer, Chrome or Firefox.

If any of the phone numbers I list in this form is for a mobile phone, I agree that:	BCBSMT may call me or any dependents 18 years old or over with prerecorded or automated calls related to my health care coverage.	☐ Y ☐ N
	BCBSMT may call me or any dependents 18 years old or over with information about new plans and benefits.	☐ Y ☐ N
If any of the phone numbers I list in this form is for a home (landline) phone, I agree that:	BCBSMT may call me or any dependents 18 years old or over with information about new plans and benefits.	☐ Y ☐ N

[1] **If you are adding one or more dependents to your existing policy, please complete the application for ALL dependents AND the Primary Applicant.**

[2] Message and data rates may apply. Terms and conditions and privacy policy at **www.bcbsmt.com/mobile/text-messaging**.

Signing up outside Open Enrollment?

Applicant Name: _____

SSN: _____

NOTE: If you are signing up during Open Enrollment, skip this page.

DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period (SEP). An SEP is a chance to sign up outside Open Enrollment.

- You must apply within 60 days before or after the qualifying life event.
- Check more than one event if more than one happened to you.
- **You must give us approved proof of a qualifying event with this application.**
- BCBSMT will review this proof to confirm that you qualify for an SEP.
- Without proof, we cannot process your form or sign you up for a health or dental plan.
- Once your policy has been issued, your SEP cannot be re-used to apply for a different plan.

Please contact your independent, authorized agent or call BCBSMT at 855-593-1515 for examples of proofs we can accept. Details about documents you need to provide are at **www.bcbsmt.com/sep**.

☐ **1.** My dependent(s) and/or I lost Minimum Essential Coverage that met the requirements of ACA: ☐ **a.** For reasons beyond my control (not including reasons like failure to pay my full premium or any disregard on my part for the plan's rules) as of this date.[1] ☐ **b.** Because someone on the plan turned age 26[2], or was legally separated or divorced as of this date.[1] ☐ **c.** Because the policyholder died as of this date.[3] ☐ **d.** Because I lost my job, I lost hours, my employer stopped making payments, or my COBRA benefits ended as of this date.[1] ☐ **e.** Because I moved away from my individual HMO plan's service area as of this date.[1] ☐ **f.** Because my plan stopped covering people in my situation as of this date.[1] ☐ **g.** Because I moved out of the service area and lost my group HMO coverage, and there were no other options with the group, as of this date.[1]	Date(s) of **Event(s)** **a.** _____ **b.** _____ **c.** _____ **d.** _____ **e.** _____ **f.** _____ **g.** _____
☐ **2.** Because I got married on this date.[3]	Date of **Event**
☐ **3.** Because I had a baby, adopted a child, had a child placed with me for adoption, took in a foster child or was otherwise ordered to cover a dependent through a court order as of this date.[3]	Date of **Event**
☐ **4.** Because there was a mistake when I signed up for my last health plan, or I have shown proof that my previous health plan or issuer broke its contract with me as of this date.[3]	Date of **Event**
☐ **5.** Because someone on my plan had a change in income and doesn't qualify for the advance payment of premium tax credit or cost-sharing reductions, or my last non-Marketplace plan broke government rules as of this date.[1]	Date of **Event**
☐ **6.** Because I got new health plan options when I moved on this date.[1]	Date of **Event**
☐ **7.** Because my current policy ends on a date other than December 31, which is this date.[1]	Date of **Event**
☐ **8.** Because my employer offered to help with the cost of coverage either through an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). **Select one:** ☐ **ICHRA** ☐ **QSEHRA** ☐ **a.** My employer is newly offering participation in an ICHRA or QSEHRA as of this date.[1] ☐ **b.** I am a new employee and my employer is offering participation in an ICHRA or QSEHRA as of this date.[1]	Date of **Event** **a.** _____ **b.** _____
☐ **9.** Because of an allowed reason I do not see on this list that happened on this date. (Please work with your agent or contact our sales center at 855-593-1515.)[1]	Date of **Event**

[1] You must apply within 60 days before or after the qualifying life event.
[2] A dependent covered under a parent's Marketplace plan has until December 31 of the year he or she reached age 26 to apply.
[3] You must apply within 60 days after the qualifying life event.

Tell us about you.

Applicant Name: _____

SSN: _____

(PLEASE ANSWER FOR **EACH** PERSON.)

PRIMARY APPLICANT[1] (Who should be listed first on the health plan?)

First Name, Middle Initial, Last Name	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English?
Y N If YES, what language? _____

Do you prefer to read or write a language other than English?
Y N If YES, what language? _____

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses Y N
If YES, when did you last use tobacco? _____

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following? (check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano
☐ Puerto Rican ☐ Cuban ☐ Other _____

OPTIONAL: Are you or do you identify as (check all that apply)
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Home Address	City	State	ZIP	County

Mailing Address (e.g., P.O. BOX)	City	State	ZIP

What is the best phone number to reach you?[2]
☐ Mobile ☐ Landline

Email Address[2,3]

Primary Care Provider (PCP) Name (FOR POS ONLY)[4,5]

PCP # (FOR POS ONLY) — Enter the 10-digit ID number

SPOUSE OR DEPENDENT CHILD[1,6] (Who else do you want to be covered on your plan?)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N
If YES, what language? _____

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses
Y N If YES, when did you last use tobacco? _____

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following? (check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

OPTIONAL: Are you or do you identify as (check all that apply)
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☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Mailing Address[2] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[2]
☐ Mobile ☐ Landline

Email Address[2,3]

Primary Care Provider (PCP) Name (FOR POS ONLY)[4,5]

PCP # (FOR POS ONLY) — Enter the 10-digit ID number

If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?
Y N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

[1] **If you are adding one or more dependents to your existing policy, please complete the application for ALL dependents AND the Primary Applicant. Proof of ineligibility for Medicare is required if you or your spouse are 65 or older.**
[2] Age 21 and older for tobacco use; age 18 and older for mail, phone and email.
[3] If you want to get information from us electronically, you **must** provide your email address.
[4] If you do not choose a PCP (see Find a Doctor at **www.bcbsmt.com**) at the time of enrollment, one will be assigned to you based on your service area. You may be responsible for the full cost of claims for services from providers that are not listed on your ID card.
[5] See note about PCPs and OB-GYNs on page 8.
[6] Dependents are up to age 26 unless medically disabled and continuing BCBSMT coverage.

Tell us about you.

Applicant Name: _____

SSN: _____

(**DEPENDENTS**[1,2], continued)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

Within the past six months, have you used tobacco?[3]
4 or more times per week on average, excluding religious or ceremonial uses

☐Y ☐N If YES, when did you last use tobacco? _____

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following? (check all that apply)

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☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[3]
☐ Mobile ☐ Landline

Email Address[3,4]

Primary Care Provider (PCP) Name (FOR POS ONLY)[5,6]

PCP # (FOR POS ONLY) — Enter the 10-digit ID number

If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?

☐Y ☐N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

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☐ Mobile ☐ Landline

Email Address[3,4]

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PCP # (FOR POS ONLY) — Enter the 10-digit ID number

If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?

☐Y ☐N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

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[3] Age 21 and older for tobacco use; age 18 and older for mail, phone and email.

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[5] If you do not choose a PCP (see Find a Doctor at **www.bcbsmt.com**) at the time of enrollment, one will be assigned to you based on your service area.

[6] See note about PCPs and OB-GYNs on page 8.

Tell us about you.

Applicant Name: _____

SSN: _____

(**DEPENDENTS**[1,2], continued)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

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4 or more times per week on average, excluding religious or ceremonial uses

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☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[3] ☐ Mobile ☐ Landline	Email Address[3,4]

Primary Care Provider (PCP) Name (FOR POS ONLY)[5,6]	PCP # (FOR POS ONLY) — Enter the 10-digit ID number

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☐Y ☐N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

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[6] See note about PCPs and OB-GYNs on page 8.

Tell us about you.

Applicant Name: _____

SSN: _____

(**DEPENDENTS**[1,2], continued)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

Within the past six months, have you used tobacco?[3]
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Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

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If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?

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Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[3] ☐ Mobile ☐ Landline	Email Address[3,4]

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[6] See note about PCPs and OB-GYNs on page 8.

Tell us about you.

(**DEPENDENTS**[1,2], continued)

Applicant Name: _____

SSN: _____

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

Within the past six months, have you used tobacco?[3]
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Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[3] ☐ Mobile ☐ Landline	Email Address[3,4]

Primary Care Provider (PCP) Name (FOR POS ONLY)[5,6]	PCP # (FOR POS ONLY) — Enter the 10-digit ID number

If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?

☐Y ☐N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N

If YES, what language? _____

Within the past six months, have you used tobacco?[3]
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Mailing Address[3] (IF DIFFERENT)	City	State	ZIP

What is the best phone number to reach you?[3] ☐ Mobile ☐ Landline	Email Address[3,4]

Primary Care Provider (PCP) Name (FOR POS ONLY)[5,6]	PCP # (FOR POS ONLY) — Enter the 10-digit ID number

If a dependent (other than spouse) is 26 or older, does dependent have a medical disability?

☐Y ☐N If YES, a Disabled Dependent Authorization Form is required. You can find the form at **www.bcbsmt.com**.

[1] **If you are adding one or more dependents to your existing policy, please complete the application for ALL dependents AND the Primary Applicant. Proof of ineligibility for Medicare is required if you or your spouse are 65 or older.**

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[4] If you want to get information from us electronically, you **must** provide your email address.

[5] If you do not choose a PCP (see Find a Doctor at **www.bcbsmt.com**) at the time of enrollment, one will be assigned to you based on your service area.

[6] See note about PCPs and OB-GYNs on page 8.

Applicant Name: _____

SSN: _____

OB-GYN ACCESS

You may get OB-GYN services from:

1) your Primary Care Provider (PCP), **or**
2) an OB-GYN. You do not need a referral from your PCP to see an OB-GYN for preventive OB-GYN services. You do not have to tell us your choice of OB-GYN before a preventive OB-GYN visit.

NOTES:

- If your PCP is part of a Limited Provider Network (LPN), the plan will cover your OB-GYN visits only if your OB-GYN is part of the same LPN.
- If choosing a POS plan, you may select an OB-GYN as your PCP. Include details about your selected OB-GYN where you are asked to identify your PCP.

Choose your health plan.

NOTE: Your coverage will start on the 1st of the month, unless otherwise required by law. Applications must be received by BCBSMT within the defined enrollment period to be accepted. Please be sure to check that your providers are in the network of the plan you choose.

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
☐ **Blue Focus Bronze POS℠ 205**	$4,700
☐ **Blue Focus Bronze POS℠ 302**	$5,200
☐ **Blue Focus Silver POS℠ 206**	$4,200
☐ **Blue Focus Silver POS℠ 306**	$4,500
☐ **Blue Focus Gold POS℠ 207**	$300
☐ **Blue Preferred Bronze PPO℠ 201**	$3,200
☐ **Blue Preferred Bronze PPO℠ 202**	$4,000
☐ **Blue Preferred Bronze PPO℠ 301**	$8,550
☐ **Blue Preferred Bronze PPO℠ 302**	$5,200
☐ **Blue Preferred Bronze PPO℠ 502**	$5,000
☐ **Blue Preferred Silver PPO℠ 203**	$800
☐ **Blue Preferred Silver PPO℠ 306**	$4,500
☐ **Blue Preferred Silver PPO℠ 308**	$8,550
☐ **Blue Preferred Gold PPO℠ 204**	$750

"CATASTROPHIC" PLAN OPTION BELOW

Here's what that means.

This plan covers essential health benefits, but only after you pay the high deductible or the out-of-pocket maximum amount. Choose this plan only if:

1) you are under age 30 before the plan year begins, **or**
2) you have a waiver from the Health Insurance Marketplace.
Your Exemption Certificate Number is required to process your form. **Exemption Certificate Number:** _____

☐ **Blue Preferred Security PPO℠ 200**	$8,550

Choose your dental plan.

Applicant Name: _____

SSN: _____

The Affordable Care Act ("ACA") requires that we seek reasonable assurance from you that you and each individual on the policy have or are seeking coverage for pediatric dental services (for children)[1]. The ACA considers coverage for pediatric dental services to be an essential health benefit (EHB) that every policy must provide, even if there is no one on the policy who is eligible to use the coverage.

Companies like BCBSMT offer this dental coverage for children through "Marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

NOTE: The dental selection on this application will apply to all applicants. If you already have BCBSMT dental coverage, whatever you select here will REPLACE that current dental coverage.

Please **SELECT ONLY ONE OPTION:**

OPTION 1 You can sign up for BlueCare Dental℠, our Full Dental QHP. This covers adults **AND** children.

BlueCare Dental (Covers Adults AND Children)	**INDIVIDUAL DEDUCTIBLE**
☐ BlueCare Dental 1A	$50
☐ BlueCare Dental 1B	$75

OR

OPTION 2 You can sign up for BlueCare Dental 4 Kids℠, our Limited Dental QHP. This covers dental services for **CHILDREN ONLY**.

BlueCare Dental 4 Kids[1] (Covers CHILD[REN] ONLY)	**INDIVIDUAL DEDUCTIBLE**
☐ BlueCare Dental 4 Kids℠ 1A	$50
☐ BlueCare Dental 4 Kids℠ 1B	$75

OR

OPTION 3 You already have or are seeking dental coverage.

Check the box and sign here to tell us that you have or are seeking what is known as a "Marketplace-certified stand-alone dental plan." Our records will show that you have the Pediatric Dental EHB from BCBSMT or another company.

Note: Checking this option will NOT result in change or cancellation to any existing coverage.

☐ **I/we already have coverage or are seeking coverage for pediatric dental essential health benefits through another policy.**

Signature (REQUIRED if selecting Option 3)	**Date**

[1] Up to age 19. Dependents 19 to 26 are considered adults for dental coverage.

Tell us how you will make your payments.

Applicant Name: _____

SSN: _____

Please be sure to read the important billing rules on the next page.
Your plan may be canceled if you don't make a payment.

FIRST PAYMENT

You may make your **first payment** by Electronic Funds Transfer (EFT), check or money order. Select your choice:

☐ EFT (First payment will be taken from your account immediately.) ☐ Check[1] (enclosed) ☐ Money order[1] (enclosed)

MONTHLY PAYMENTS

You may make your **monthly payments** by Electronic Funds Transfer (Auto Bill Pay), or we can send you a bill by email or mail. Select your choice:

☐ EFT (Auto Bill Pay) ☐ Bill by email[2] ☐ Bill by mail

PREMIUM PAYMENT INFORMATION (if paying by EFT):

Please check one ☐ Checking Account ☐ Savings Account	**Name(s) on account if other than the Applicant**
Bank routing number (please verify)	**Account number** (please verify)

AGREEMENT

I request and authorize BCBSMT and/or its designee to obtain payment of first and/or monthly premium amounts becoming due on the last day of the month prior to the following month's coverage by initiating charges from my checking or savings account in the form of checks, sharedrafts, or electronic debit entries. I request and authorize the Financial Institution named here to accept and honor the same from my account.

☐ **I have read and accept this agreement**

Account owner's signature	**Date**	**Relationship to Applicant**

[1] **TIP:** Write the name of the Primary Applicant in the memo/notation on check or money order if different from name of account owner. **NOTE:** Use of a business account may require proof of compliance with Third Party Payment Rules on Page 11.

[2] If you want to get information from us electronically, we **must** have your email address. BCBSMT will send bills to the Primary Applicant email address.

NOTE:

Do not cancel any current coverage you may have until your Application is approved and your new plan is effective.

Your first month's payment is due when you sign up. If you are signing up for a new plan, your coverage will not be in effect until we receive your first payment.

Important billing rules.

Applicant Name: _____

SSN: _____

ELECTRONIC FUNDS TRANSFER (EFT) BILLING RULES

If you allow EFT, you understand and agree that BCBSMT and/or the company BCBSMT chooses to process payments may withdraw monthly payments from your checking or savings account in accordance with the terms below:

- Payments are due on the last day of the month before the month of coverage.
- Payment will be made as you choose on the previous page.
- Your bank or credit union will process these payments.
- If the payment date falls on a nonbusiness day or a holiday, the payment will be taken on the next business day.
- Please make sure you have enough money in your account when you submit this Application. If a payment is denied for non-sufficient funds (NSF), BCBSMT may try to process the charge again at any time in the next 30 days. BCBSMT will not pay you back for any fees your bank or credit union charges you for not having enough money in your account.
- Both the bank or credit union and BCBSMT reserve the right to end this payment program or your participation in it if payment is denied for NSF. This means payments would not be made automatically anymore. Coverage may stop (claims would not be paid) if you do not pay your monthly bill.
- To change the bank or credit union these payments are paid from, you will need to give at least 15 days' notice to BCBSMT by telephone before a scheduled payment date.

THIRD PARTY PAYMENT RULES

BCBSMT accepts premium or cost-sharing payments for members from these four sources only:

1. You

2. Your family, or someone who has your Power of Attorney, a Legal Guardian or a Trust

3. Authorized Entities
Under the law, BCBSMT accepts payments from Authorized Entities. At this time, Authorized Entities include:
a. Ryan White HIV/AIDS programs, under Title XXVI of the Public Health Service Act
b. Indian tribes, tribal organizations and urban Indian organizations
c. State and federal government programs as described in 45 C.F.R. § 156.1250.

4. Private nonprofit foundations that pay:
a. for the entire coverage period of your contract,
b. no matter your health status, and
c. no matter what company or benefit plan you choose

Payments made by a third party that is not shown above will not be accepted for your account. This may end or cancel the coverage.

I understand:
- My BCBSMT plan will not be a group health plan sponsored by an employer.
- This coverage is not meant to be an employer-sponsored group health insurance plan in any way.

I agree that (except in the case of an Individual Coverage Health Reimbursement Arrangement):
- My employer (if any) will not pay any part of my monthly bill or copays.
- My employer (if any) will not pay me back for these payments now or in the future.

PAST DUE PAYMENT POLICY

When you renew your Blue Cross and Blue Shield of Montana coverage or reenroll by selecting a new product, you will need to be current on premium payments. Any past due premium payments for coverage that Blue Cross and Blue Shield of Montana provided will be due at the start of the new plan year, in addition to current premium charges. **New coverage will not be effective until all such payments are made.**

Tell us about other coverage.

Applicant Name: _____

SSN: _____

COVERAGE YOU ARE REPLACING

Will this plan replace health coverage for 2021 you already have? **If yes, read KNOW YOUR RIGHTS below and list all coverage that you plan to terminate and replace with a BCBSMT plan:**	☐ Y ☐ N

COVERED PERSON(S)	NAME OF INSURANCE COMPANY	POLICY NUMBER	TERMINATION DATE

KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, BCBSMT does NOT automatically cancel your old policy. This section just confirms that you plan to cancel your current accident and health plan and replace it with a BCBSMT plan. For your own information and protection, you should know how this decision may affect the coverage available to you in a new plan.

1. You may want to ask the company that offers the plan you are replacing about your decision. You could also talk to their agent. This is your right. It is in your best interest. You should be sure you understand all the issues you may have if you replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be sure to truthfully and completely answer all questions on this Application about any person applying for coverage. If you leave out any important information, BCBSMT may have a legal basis to deny any future claims and to refund your premium as though your contract had never been in force. Before you sign the completed Application, re-read it carefully to be sure that all information is correct.

OTHER MEDICAL,DENTAL OR VISION COVERAGE YOU OR YOUR DEPENDENT(S) MAY HAVE

Does any person applying for coverage currently have, or did they previously have within the last 60 days: • BCBSMT coverage? • Health coverage with any other insurance company? • Coverage under a tax-supported or government program, including Medicare? **If yes, please provide details below:**	☐ Y ☐ N

Applicant Name	**Name on Other Policy** (if applicable)	**Member/Group ID** (recommended)
Applicant Name	**Name on Other Policy** (if applicable)	**Member/Group ID** (recommended)

Proxy statement (OPTIONAL)

By purchasing a BCBSMT health plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). By signing this application, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:

- This permission will apply to any company that replaces HCSC
- The Board of Directors may appoint someone to vote for me

The annual meeting of members is scheduled to take place each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called if needed. Notice of any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 14 to complete this application.	**Date**
Print your name as you signed it:	

Please read and sign on next page.

Applicant Name: _____

SSN: _____

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Application is not coverage. Coverage will not begin until (1) the effective date of the policy and (2) the first month's payment is made.[1]
- If I use an agent, they cannot accept risks or change BCBSMT policies or rules.
- If an agent was helping me to purchase an individual or family health or dental plan, BCBSMT may pay the agent a commission and/or other payment. If I want more detail about any payment to the agent, I should ask the agent.
- If any person knowingly submits a false claim for payment of a loss or benefit or falsely misstates an important fact on this Application, coverage may be rescinded. This includes false claims or facts about me or any of my dependents. Rescission cancels the coverage back to the first day it became effective. I will be given at least 30 days' written notice before my coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the State's Department of Insurance and other applicable state and federal laws and regulations. Rates are calculated based on age, tobacco use and geographic rating factors. These factors are also used to calculate premiums for any dependents covered on my policy.
- I authorize any of the following people or organizations to share my health information with BCBSMT or their authorized representative:
    - Health professionals, hospitals, or clinics
    - Other health or health-related facilities
    - Government agencies
    - Pharmacy benefit managers, clearinghouses, or retail stores
    - Any other persons or firms required by law
  - This information may include:
    - Copies of records about advice, care or treatment that were given to me and/or my dependents
    - Information about the prescription and use of drugs or alcohol (without limitation)
    - Information about mental illness
  - BCBSMT may review and research its own records for information.
  - BCBSMT will share collected information only as needed with medical entities to help manage my care.
  - Information shared with my authorization may be re-shared by BCBSMT as allowed or required by law. If such sharing is required, the person or agency getting the information will be responsible for protecting it.
  - This authorization is valid for two years from today, or until I cancel coverage.
    - I have the right to cancel the authorization at any time, in writing, by contacting BCBSMT.
    - I or anyone I authorize to represent me will receive a copy of this authorization upon request.
    - Any cancellation will not affect the activities of BCBSMT before the date such cancellation is received by BCBSMT.
- I present any statements and answers on this Application as FACTS. To the best of my knowledge and belief, they are true and complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSMT and me.
- My agent (if I have one) and I confirm that I have read and understood the Application and reviewed the details of the plan I chose.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application, will pay BCBSMT directly.
- BCBSMT does not accept payments directly from third parties except from those listed on page 11.
- If these rules are broken, any payments made by a third party will not be credited to my account or coverage. These payments may not be refunded to me. This may result in the cancellation of my coverage for nonpayment.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.

[1] Some exceptions during SEP. Check with your BCBSMT agent or Customer Service.

Did you work with an agent?

Applicant Name: _____

SSN: _____

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given.
- I provided written material to explain the benefits to the Applicant(s). This includes details about what may not be covered and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes the Disclosure Statement(s) when requested.

Agent's Signature	**Date**	**Agent ID**
Print Agent's Name	**Agent's Phone**	
Agent's Email		

Please read and sign below.

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PROCESSED		
Primary Applicant's Printed Name AND Signature		**Date**
Parent or Legal Guardian of a Minor Child Printed Name AND Signature (if child is the Primary Applicant)		**Date**
If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:		
Personal Representative's Printed Name AND Signature	**Relationship**	**Date**
Do you permit any adult spouse or dependent listed on pages 3-7 of this form to answer questions about your application? ☐ Y ☐ N		

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSSIBLE, REMEMBER TO:

- Sign your form.
- Send **ALL PAGES** of the form, **EVEN IF SOME ARE BLANK**.
- If you are working with a BCBSMT agent, please include your agent's information above.

SEND BY MAIL	Blue Cross and Blue Shield of Montana Attn: Individual Enrollment, P.O. Box 660819, Dallas, TX 75266-0819
SEND BY FAX	800-279-7419
QUESTIONS?	If you have any questions, please call your agent or call BCBSMT toll-free at 855-593-1515.

Please include all necessary materials when submitting this Application.

If you are the Legal Guardian for anyone listed on the application, please enclose a signed court decree.
Visit **discoverbcbsmt.com** for frequently asked questions about membership, payment and benefits.

BlueCross BlueShield of Montana

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Montana

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.