



NEBRASKA

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 3248 • Omaha, Nebraska 68180-0001

City of Lincoln Health Enrollment Form

Please print and complete this enrollment form with black ballpoint pen. Be sure to complete all questions in full. Incomplete enrollment forms cause unnecessary delays. If you need more space for any answers, you can use a separate piece of paper. Please include your name and social security number.

- New Application (Complete all sections except Section C)
- Change (Complete all sections except Section B, if applicable)

A. APPLICANT INFORMATION

Social Security Number	Name (Last)	(First)	(M.I.)	(Title)	Date of Birth (Mo., Day, Year)
Address (Street, P.O. Box)	(City)	(State)	(Zip+4 Code)	(County)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone Number () ()	Group Name (Employer or Organization) City of Lincoln	Group Number 305008	Date of Hire (mm/dd/yyyy)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	

Are you or your dependent(s) terminating other Blue Cross and Blue Shield of Nebraska coverage? Yes No
If yes, please give reason and date: _____

B. HEALTH ELECTION(S) FOR NEWLY ELIGIBLE EMPLOYEES:

I HEREBY APPLY FOR:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family
- Waive

CITY OF LINCOLN OFFICIAL USE ONLY:

Effective Date.: _____
Dept.: _____

C. HEALTH CHANGE ELECTION FOR CURRENTLY ENROLLED EMPLOYEES

I HEREBY APPLY FOR THE FOLLOWING CHANGES IN COVERAGE:

- Change to Employee Health
- Change to Employee + Spouse
- Change to Employee + Child(ren)
- Change to Family

Give Reason for Change and Date of Event: () Divorce () Spouse Deceased () Marriage () Other: _____ Date: _____
 Add New Dependent(s): Date Dependent(s) joined your household: _____ (Complete Section D)
 Other Health Changes: _____

D. PERSONAL DATA

List below spouse and other dependent(s) to be covered including eligible children under age 26. List in order of age – oldest first.

Full Name (Last, First, M.I.)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex		Relation to Employee
			M	F	

E. I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical information to the extent necessary for processing claims. I authorize my employer to deduct from my earnings any required premiums.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS NOTICE

This Plan does not impose a waiting period for pre-existing conditions. This means that if you have a medical condition before coming to our plan, you do not have to wait a certain period of time before the plan will provide coverage for that condition.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

To request special enrollment or obtain more information contact City of Lincoln or Blue Cross and Blue Shield of Nebraska Member Services Dept. at (402) 390-1820 or toll-free 1-800-642-8980.

Signature of Applicant: _____ Date: _____