

*Please select and read the instructions below that apply to the changes you are making:*

You may complete the form either by typing directly onto the form (use your TAB key to navigate) or just print off and handwrite your choices.

**To Enroll:**

1. Complete sections:
  - A. Employee Information
  - B. Dependent Information
  - C. Membership choices: Select the coverage you wish to enroll, i.e. health choice, single/family.
  - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
  - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

**To Drop Coverage:**

1. Complete sections:
  - A. Employee Information
  - C. Check Terminate Coverage box(es). Print and sign the waiver line.
2. Mail or bring the form to the Office of Human Resources.

**To Change Status of your Coverage:**

1. Complete sections:
  - A. Employee Information
  - B. Dependent Information
  - C. Membership Choices: Select the coverage you wish to change to, i.e. health choice, single/family.
  - D. Complete only if you will be covered by another insurance over the next year in addition to Concordia's coverage
  - E. Print the form and sign this section
2. Mail or bring the form to the Office of Human Resources.

**PART A – EMPLOYEE INFORMATION**

<b>Employee's Name</b>	Last	First	M.I.	<b>Social Security Number</b>
<b>Employee's Home Address</b>	Address		City	State
	Day Phone Number (w/ area code) ( )		Evening Phone Number (w/ area code) ( )	
<b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			<b>Date of Birth (M / D / Y)</b>

**PART B – DEPENDENT INFORMATION**

Relationship to Employee	First	M.I.	Last (if different from employee)	Social Security Number	New Dependent	Gender (M/F)	Date of Birth M/D/Y	Over Age 19 & Full Time Student
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Note:** Dependent children age 19 to age 25 must be full-time students to be covered by Concordia College's medical/dental plan; these dependents however do not qualify for the Ortho portion. If the dependent's last name is different from your own, please attach explanation

**PART C – YOUR BLUECROSS BLUE SHIELD HEALTH INSURANCE CHOICES**

<p><b>\$250/\$500 Deductible Plan</b></p> <input type="checkbox"/> Elect: ___Single ___Family <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Waive	<p><b>\$750/\$1500 Deductible Plan</b></p> <input type="checkbox"/> Elect: ___Single ___Family <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Waive
--	---

**Benefit Waiver (sign ONLY if declining coverage).** I understand that by waiving coverage for **myself and/or my dependents** I cannot elect to participate until next year unless I experience a status change in accordance with the IRS section 125 and submit the change within 30 days of the status change. BCBSMN reserve the right to decline any further enrollment changes.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART D – OTHER INSURANCE/MEDICARE COVERAGE (If does not apply skip to PART E )**

**Health**  
Do you or any family member applying for coverage currently have other medical coverage or Medicare? (please complete the following)

Name of Insurance Co: \_\_\_\_\_ Name of the Individual with Coverage: \_\_\_\_\_

Policy/ID No.: \_\_\_\_\_

**PART E – AUTHORIZATION OF COVERAGE**

I hereby enroll for coverage. I authorize my employer to deduct my premiums before taxes are calculated (premium conversion). Employees will automatically be enrolled in this portion of the Section 125 plan. I understand that I cannot make change or revoke my election for one plan year unless I experience a status change in accordance with the IRS Section 125 and submit the change within 30 days of the status change. You may opt out of the before tax deduction by checking here:  By checking this box, I am requesting after tax deductions.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**GROUP ENROLLMENT INFORMATION – THIS PORTION TO BE COMPLETED BY EMPLOYER**

<input type="checkbox"/> New Hire Start Date _____ Effective Date _____	<input type="checkbox"/> <b>Qualifying Event</b> <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change in employment status <input type="checkbox"/> Termination/Voluntary Resignation <input type="checkbox"/> Other (Details) _____	Date Event Occurred: _____ Effective Date of Coverage: _____ End Coverage Effective: _____
---	--	--

**Group Name**  
Concordia College Office of Human Resources, 901 8<sup>th</sup> St S, Moorhead, MN 56562

**BCBSMN Group:** EP606-W0      **Delta Dental MN Group:** 50814

**Group Representative's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone Number:** (218) 299-3339