U of M Student Continuation Options

Enrollment Form Instructions

1. Please complete this entire enrollment form including all explanations as requested. Print clearly using black or blue ink. Incomplete enrollment form will be returned to you to be completed. This may affect the date your coverage starts.
2. Sign and date this enrollment form. This enrollment form must be received at the home office of Blue Cross within 15 days of your signature.
3. The enrollment form can be mailed to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164 or fax 651-662-6433 or email Enrollment_forms@bluecrossmn.com.
4. A Summary of Benefits and Coverage (SBC) is available to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by calling 1 of the phone numbers listed below.

General Information

- Individuals (whether you or any dependent) enrolled in or receiving benefits under Medicare Part A and/or Part B are not eligible to enroll in an individual commercial plan. If you enroll in a Blue Cross individual commercial plan, you must immediately notify Blue Cross if you or (any dependent) enroll in or obtain health insurance benefits under a Medicare program after submitting this enrollment form or at any time during your period of coverage in the Blue Cross plan.
- Enrollees age 20 and under applying as the contract holder may only have single coverage.
- If eligible, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.
- Pediatric dental is an essential health benefit available for purchase through a separate contract with Delta Dental. For additional information on available pediatric dental plans, please visit www.bluecrossmn.com, and search for "pediatric dental".

After you submit your enrollment form

- You will receive your contract, ID cards, and first bill or automatic withdrawal notification within two (2) weeks.

Ready to apply?

- Contact the Student Health Benefits Office at 612-624-0627 or 1-800-232-9017 or go online: shb.umn.edu.
- This information is also available in other ways to people with disabilities by calling Customer Service at (651) 662-5030 (voice), or 1-800-521-6685 (toll free), or (TDD) call (651) 662-8700, or 1-888-878-0137 (TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech).
- Hours: 8 a.m.-5 p.m. Central Time, Monday – Thursday; 9 a.m.-5 p.m., Central Time, Friday.
- Attention: If you want free help translating this information, call the above number.
- Atencion. Si desea recibir asistencia gratuita para traducir esta informacion, llame al numero que aparece mas arriba.
- For Readability and Accessibility call 651-667-5040 or 1-800-711-9875.

19554R08 (1014)  Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.
Individual Enrollment Form

A  Enrollee Information

Identification Number __________________________ (Begin with X241)

Enrollee Name _______________________________ _______________________________ Legal Marital Status ___ Single ___ Married

Enrollee address _______________________________ Street including Apt

City _______________________________ State _______ Zip ___________ County _______________________________

Billing address _______________________________ Streets

City _______________________________ State _______ Zip ___________ County _______________________________

Preferred telephone number ( _______ ) Alternate telephone number ( _______ )

Telephone type: □ home □ cell □ work

Telephone type: □ home □ cell □ work

Preferred Email address _______________________________ Alternate Email address _______________________________

Starting with Enrollee, list each dependent(s) applying for coverage.

In order to be added at this time, you and/or your dependent(s) must have been enrolled on the University Student Health Benefit Plan (USHBP). Social Security Numbers (SSN) for you and your dependents are requested for benefit administration and reporting to the Internal Revenue Service (IRS) so you may demonstrate having minimum essential coverage and avoid having to pay a tax penalty. Please include SSNs with your application.

<table>
<thead>
<tr>
<th>#</th>
<th>First</th>
<th>Last</th>
<th>Social Security Number</th>
<th>Relationship to Enrollee</th>
<th>Birth Date</th>
<th>Sex</th>
<th>MF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Additional dependent(s) on attached page

B  Payment Selection

Choose your preferred payment option, applies to both medical and dental, the two (2) options will be:

☐ Monthly automatic withdrawal; or ☐ Bill me monthly

C  Coordination of Benefits

1. Will you or any dependent(s) applying for coverage currently have Blue Cross and Blue Shield of Minnesota coverage?
   Yes No
   If Yes:
   Dependent Name __________________________ Identification Number __________________________

2. Will you or any dependent(s) listed under this plan be enrolled in other health or medical coverage once this policy is in force?
   Yes No
   If the response is Yes, you may be contacted for more information.

3. Will you or any dependent(s) named on this Enrollment Form be enrolled in either Medicare Part A or Medicare Part B or both?
   Yes No

1955-9088 (10/14)  Page 2  (Continued on page 3)
Plan selection

BlueAccess

<table>
<thead>
<tr>
<th>Single/family coverage</th>
<th>Aware Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% Plan</td>
<td></td>
</tr>
<tr>
<td>□ $1,500 Plan 237 (AATW)</td>
<td></td>
</tr>
<tr>
<td>80% Plans</td>
<td></td>
</tr>
<tr>
<td>□ No Deductible Plan 241 (AASQ)</td>
<td></td>
</tr>
<tr>
<td>□ HSA $2,000/$4,000 Plan 238 (AATS)</td>
<td></td>
</tr>
<tr>
<td>90% Plan</td>
<td></td>
</tr>
<tr>
<td>□ No Deductible Plan 242 (AASS)</td>
<td></td>
</tr>
<tr>
<td>100% Plans</td>
<td></td>
</tr>
<tr>
<td>□ HSA $1,800/$3,600 Plan 240 (AASN)</td>
<td></td>
</tr>
<tr>
<td>□ HSA $3,000/$6,000 Plan 239 (AATP)</td>
<td></td>
</tr>
<tr>
<td>□ HSA $4,500/$9,000 Plan 236 (AASX)</td>
<td></td>
</tr>
<tr>
<td>□ HSA $5,200/$10,400 Plan 236 (AAT3)</td>
<td></td>
</tr>
</tbody>
</table>

The deductible, copay and out-of-pocket maximum amounts are subject to annual adjustments.

Effective date of coverage

Enrollment forms must be received within 60 days from the termination date of the U of M Student coverage.

- The effective date will be the day after the termination date of your U of M student coverage as assigned by SHBP Boynton Health Services.
Authorization and representation

I understand and agree that coverage, if approved, will begin as specified in section E on page 3. I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my check and I will not receive my check back from my financial institution.

I understand that coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

For purposes of obtaining information in connection with this enrollment form, reinstatement, or change in policy benefits, this release is valid as long as I am continually insured with the insurer. I am entitled to receive a copy of any release I sign.

I agree if I am enrolling in a product that features certain designated providers, Blue Cross may share my name, address and telephone numbers, as well as my past, current and future health and account records with such designated providers about services I have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate my care and to improve the quality of that care.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this enrollment form in the decision whether to accept the enrollee and/or dependent(s) listed on this enrollment form for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the enrollment form, even if I and/or dependent(s) listed on this enrollment form, currently have coverage or had prior coverage with Blue Cross.

I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I understand that this plan does not include coverage for the pediatric dental essential health benefit and that Blue Cross has made me aware of pediatric dental coverage available for purchase through Delta Dental.

I agree to notify Blue Cross immediately of any change in my and/or dependent(s) enrollment information between the date of this enrollment form and the effective date of coverage. Failure to notify Blue Cross of any change in the information contained on this enrollment form may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependent(s) enrolling for coverage.

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Cross will act in reliance upon the information I have provided on this enrollment form which materially affect enrollment eligibility may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

If this enrollment form is completed as an electronic or online enrollment form, both parties agree to conduct this transaction electronically.

X

[Signature]

Enrollee, Parent, Legal Guardian or Guarantor Signature
If contract is for a minor

For University of Minnesota Student Health Benefits Office Use Only

Termination date of SHBP coverage: JAN 19 2015

Office of Student Health Benefits signature: