BLUECROSS BLUESHIELD OF MN

Group Employee Enrollment Form

Last Name	First Name	MI	Date of Birth	Social Security Number	Phone Number

Address

E-mail address

List All Individuals to be Added

Last Name	First Name	MI	Sex	Social Security Number	Birthdate	
						Self
						Spouse
						Child
						Child
						Child
						Child

Benefit Selection

_____ Elect _____Waive Health(Self)

_____Elect _____Waive Health(Dependents)

Health Plan Choice

_____ $2600/$5200 VEBA

_____ $5000/$10000 VEBA

_____ $7500/$1$000 VEBA

_____ $1,000/$2000 Deductible

_____

Signature of Employee Date

I understand that providing false information in this application may result in the denial of claim or cancellation of coverage.