SAVE TIME
APPLY ONLINE
bcbswy.com/shopping

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Application for BlueSelect Individual and Family Coverage

DIRECTIONS: *Complete this application using the keyboard on your computer. Once you are finished, please print it, sign the back and return it to:* ***BCBSWY; PO Box 2266; Cheyenne, WY 82003.***

Step 1➢ Select qualifying event:
☐ Open Enrollment Period ☐ Marriage ☐ Loss of other coverage
☐ New Wyoming Resident ☐ Birth ☐ Adoption (attach proof)
☐ Other _____

Date of Event: _____/_____/_____

Step 2➢ Select a Plan Type: ☐ One Adult ☐ Two Adults ☐ Adult w/Dependents ☐ Family ☐ Child Only*
(one child per application)

Step 3➢ Select a Plan Option:

Gold	**Silver**	**Bronze**	**Catastrophic****
☐ Basic	☐ Basic	☐ Basic	☐ Basic
☐ Classic	☐ Classic	☐ Classic	
☐ HealthPlus	☐ ValueOne	☐ Value	
☐ Core	☐ ValueTwo	☐ Core	
	☐ HealthPlus		
	☐ Core		

Step 4➢ **Please read carefully:** The Affordable Care Act requires your medical plan to include coverage for pediatric dental services unless you have purchased a separate standalone dental plan that provides for this coverage. Based on this requirement, the BCBSWY Plan Option you selected will include kid's dental coverage unless you check the box below indicating that you already have pediatric dental coverage.

☐ I have a separate standalone plan that provides coverage for pediatric dental services and wish to apply for a BCBSWY plan without kid's dental coverage.

** The Child Only option should be selected for applicants whose coverage will be effective prior to December 31st of the year in which they turn 21.*
*** The Catastrophic plan is available to individuals whose coverage will be effective prior to December 31st of the year in which they turn 30. The age limitation applies to ALL individuals to be covered under the policy.*

Applicant's Name: _____ Email Address: _____

If Child Only coverage, please indicate responsible party: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Applicant Tobacco Use (Y/N)†: _____

Social Security #: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Print the names and dates of birth for spouse (MUST BE A WYOMING RESIDENT) and children age 26 and under to be covered.

First Name, Last Name	Gender (M/F)	Date of Birth	Age	Relationship (e.g. Spouse, Child)	Social Security Number	Tobacco Use (Y/N)†

†*Indicate "Y" for each individual who has used tobacco on average 4 or more times per week within the past 6 months, excluding religious or ceremonial uses.*

Billing Preference: ☐ Bank Draft (Monthly) ☐ Bank Draft (Quarterly) ☐ Direct Bill (Monthly) ☐ Direct Bill (Quarterly)

Automatic Bank Withdrawal Authorization:
I authorize Blue Cross Blue Shield of Wyoming (BCBSWY) to withdraw health insurance charges from the account at the bank listed below. This authorization will remain in effect until I notify BCBSWY to cancel my coverage or change my payment option.
Important: In order to process this authorization, we require a voided check to be submitted with this application.

Account Number: _____ ☐ Checking ☐ Savings

_____ of _____
Name of Bank City, State, Zip

Bank Account Holder's Signature: _____ Date: _____

Required to process this application: Complete the following for ALL individuals named on this application who currently have, or who had in the past year, other health coverage. Attach extra pages which you have signed and dated, if necessary. If there is no other existing or prior coverage, please indicate by writing "NONE."

Policyholder's Name: _____ Covered Individuals: _____

Name of Insurance Company: _____ Insurance Company Phone: _____

Policy #: _____ Coverage Ended (MM/DD/YY)_____

Name of Employer: _____

If still in effect, will the coverage described above be cancelled when this Blue Cross Blue Shield of Wyoming coverage becomes effective? ☐ Yes ☐ No

If no longer in effect, did the coverage described above terminate for ANY of the following reasons: Termination of employment; Termination of the employer's contribution to coverage; Termination of the other health plan's coverage with the employer; Death of a spouse; Divorce or Legal Separation; Loss of Medicaid or Kid Care CHIP Coverage? ☐ Yes ☐ No

If yes, please attach a termination letter from the insurance company which includes the termination date, reason for termination and the individuals who were covered.

A. I understand that upon acceptance of my application, my coverage will become effective on the date established by Blue Cross Blue Shield of Wyoming.

B. I certify that the statements made on this application are true.

C. I realize that any act, practice, or omission I have performed that constitutes fraud or intentional misrepresentation of material fact asked for on this application will render the contract null and void or subject to cancellation, rescission, or to disallowance of the individual about which the fraudulent act, practice, omission, or intentional misrepresentation of material fact occurred.

D. I understand that I am applying for coverage that contains expanded wellness benefits that meet the requirements of the Patient Protection and Affordable Care Act. The expanded wellness benefits require the use of an in-network provider. For a full description of these benefits, please see the Benefit Document. The comprehensive adult wellness benefits provided do not meet the minimum standards as defined by the Wyoming Insurance Code.

E. I understand that the coverage applied for is not an employer sponsored group health plan, and no portion of the premium will be paid, during the period the coverage is in force, by or on behalf of an employer either directly or through wage adjustments or other means of reimbursement.

F. I certify that I have obtained coverage for pediatric dental services either by applying for a BCBSWY plan with kid's dental coverage or by purchasing a separate standalone pediatric dental plan.

I have read and I understand items A through F above. I hereby apply for coverage with Blue Cross Blue Shield of Wyoming, an independent licensee of the Blue Cross and Blue Shield Association, under the terms and conditions as stated in the Benefit Document, including the Coordination of Benefits provision.

SIGN HERE: _____ _____
Applicant's Signature Date

AGENT USE ONLY

Are you aware of any information not disclosed in this application for coverage? ☐ No ☐ Yes Explain: _____

Was this application completed by the applicant? ☐ Yes ☐ No Explain: _____

_____ _____ _____
Agent's Signature Agent Number Date

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

This Notice is Being Provided as Required by the Affordable Care Act

Translation Services

If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming 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 800-442-2376.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-442-2376 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.

Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.

Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.

ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Wyoming
についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。

यदि तपाई आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ,Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा नि:शुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Wyoming ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید.800-442-2376 تماس حاصل نمایید.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે ખર્ચ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે,આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.

Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Wyoming haada yit'éego bína'ídílkidgo éí doodago háida biká anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnil 800-422-2376.

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Non-Discrimination Notices

Blue Cross Blue Shield of Wyoming (BCBSWY) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

BCBSWY provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

BCBSWY provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

In order to obtain the interpretation services listed in paragraphs two (2) and three (3), Participants may call (800) 442-2376 or use BCBSWY's Telecommunications Device for the Deaf (TDD) at (800) 696-4710.

Participants have the right to file a grievance regarding potential discrimination. To file a grievance, please call BCBSWY at (307) 634-1393 or (800) 422-2376 and request the Grievance Officer in the Legal Department or mail a letter describing the grievance to 4000 House Avenue, Cheyenne, WY 82001 to the attention of the Legal Department.

If a Participant believes they have been discriminated against because of their race, color, national origin, disability, age, sex or religion, the Participant may file a discrimination complaint with the Office of Civil Rights. Please visit www.hhs.gov/ocr for directions to file a complaint.