NEBRASKA

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

Non-Underwritten Change Application

Individual Underwriting Department
P.O. Box 2417 • Omaha, NE 68103-2417
nebraskablue.com

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Please Print.

Section I — Insured Information

a. Insured's Name (Last, First, M.I., Title)	**b.** Social Security Number **or** BCBSNE ID Number
c. Address (Street, P.O. Box, Apt. #, City, State, Zip + 4 Code)	

Section II — Health Plan Election

I wish to change my coverage to the following plan option selected below. Please select one plan/deductible option below and initial any disclaimer needed.

Plan	Options	Disclaimer
BlueEssentials*	☐ 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 3500 **Add Maternity:** ☐	* **BlueEssentials or BlueEssentials HSA-eligible plans** I understand that the BlueEssentials and BlueEssentials HSA-eligible plans Pay No Benefits for Inpatient or Outpatient Treatment of Mental Illness, Alcoholism and/or Drug Abuse, and unless I have elected to add Maternity these plans Pay No Benefits for Pregnancy/Maternity. **(YOUR INITIALS ➔ ____________)**
BlueEssentials HSA-eligible*	**Single:** ☐ 1500 ☐ 2500 ☐ 3500 ☐ 5000 ☐ 6000 **Family:** ☐ 3000 ☐ 5000 ☐ 7000 ☐ 10,000 ☐ 12,000 **Add Maternity:** ☐	
BlueEssentials Choice**	☐ 1000 ☐ 2500 ☐ 5000 ☐ 7500 ☐ 10,000 **Add Maternity:** ☐	** **BlueEssentials Choice or BlueEssentials Choice HSA-eligible plans** I understand that the BlueEssentials Choice and BlueEssentials Choice HSA-eligible plans Pay No Benefits for Inpatient or Outpatient Treatment of Mental Illness, Alcoholism and/or Drug Abuse, and unless I have elected to add Maternity these plans Pay No Benefits for Pregnancy/Maternity. **(YOUR INITIALS ➔ ____________)**
BlueEssentials Choice HSA-eligible**	**Single:** ☐ 1500 ☐ 2500 ☐ 3500 **Family:** ☐ 3000 ☐ 5000 ☐ 7000 **Add Maternity:** ☐	
ValuePlan***	☐ 750 ☐ 1000 ☐ 1250 ☐ 1500 ☐ 2000 ☐ 2500 ☐ 3000 ☐ 3500 ☐ 5000	*** **ValuePlans or ValuePlans HSA-eligible plans** I understand that the ValuePlans or ValuePlans HSA-eligible plans Pay No Benefits for Pregnancy/Maternity; or for Inpatient Treatment of Mental Illness, Alcoholism and/or Drug Abuse. **(YOUR INITIALS ➔ ___________)**
ValuePlan HSA-eligible***	**Single:** ☐ 1200 ☐ 1500 ☐ 1800 ☐ 2250 ☐ 2700 ☐ 2900 **Family:** ☐ 2400 ☐ 3000 ☐ 3600 ☐ 4500 ☐ 5400 ☐ 5800	
Blue*Preferred* Basics****	☐ Plan 1 - 5000 ☐ Plan 2 - 2000 ☐ Plan 3 - 3000 ☐ Plan 4 – 0 *Spouse and Dependent coverage is not available on BluePreferred Basics Plan 1, 2, or 3*	**** **Blue*Preferred* Basics** I understand that the Blue*Preferred* Basics Plans Pay No Benefits for Pregnancy/Maternity; or for any Treatment of Mental Illness and/or Drug Abuse; that Basics Plans 1 and 2 provide Inpatient Coverage Only; and that Spouse and Dependent Coverage is not available for Basics Plans 1, 2 or 3. **(YOUR INITIALS ➔ ____________)**
SelectBlue (3-Tier Network Plan)**	☐ Option 1 – 1500 ☐ Option 2 – 2500 ☐ Option 3 – 1000 ☐ Option 4 – 2000 **Add Maternity:** ☐	** **SelectBlue or SelectBlue HSA-Eligible plans** I understand that the BlueEssentials Choice and BlueEssentials Choice HSA-eligible plans Pay No Benefits for Inpatient or Outpatient Treatment of Mental Illness, Alcoholism and/or Drug Abuse, and unless I have elected to add Maternity these plans Pay No Benefits for Pregnancy/Maternity. **(YOUR INITIALS ➔ ___________)**
SelectBlue HSA-eligible (3-Tier Network Plan)**	☐ Option 1 – 5000 ☐ Option 2 – 3000 **Add Maternity:** ☐	

Social Security Number	Proposed Insured's Name (Last, First, M.I., Title)

Section III Optional Coverage

DentalEssentials ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4

Section IV Summary of Benefits and Coverage Acknowledgement

☐ I acknowledge receipt of the Summary of Benefits and Coverage (SBC) or have been given information about how to access the SBC online at the time I completed this application.

Section V Other Change

List any other change(s) needed in the space provided below.

Please change my Agent of Record to Chad Larson, Agent# AA68 effective immediately so that

he may counsel and service my health insurance plans.

Section VI Signatures

✕ Signature ______________________________ Date ______________

✕ Signature of Agent ______________________________ Date ______________

For Internal Use Only	Group Number ______________ Basic Code ______________ Initials ________