

15. I hereby enroll in the following coverage:

- CMM with copay**
- CMM with calendar year deductible of \$1,500**
- High Deductible Health Plan 100 compatible with an HSA.**
 - Single Coverage (pkg 1)**
 - \$2,900
 - \$5,000
 - Family Coverage (pkg 2)**
 - \$5,800
 - \$10,000

16. **TO BE SIGNED BY ENROLLEE (AND SPOUSE IF DEPENDENT COVERAGE ENROLLMENT REQUESTED)**

I have read this entire enrollment form and I declare all information, statements and answers herein to be true and complete. I certify that I am a member of the Association identified on the reverse side of this enrollment form.

This certificate does not cover charges for treatment of an illness that was diagnosed or treated during the six (6) months immediately before coverage became effective under this certificate until the certificate has been in force for at least 12 consecutive months or for late enrollees, 18 consecutive months. Credit will be given for the time period for which you have maintained continuous qualifying prior coverage to reduce your specific preexisting condition limitation period. "Treatment" means the management and care of an illness, and includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

Enrollee's Signature

Telephone Number

Date

Spouse's Signature (if enrollment requested)

Date

17. **Enrollment Instructions**

a. Mail completed enrollment form to:

Marsh Affinity Group Services
333 S. 7th St.
Suite 1600
Minneapolis, MN 55402

or you may fax it to Attention: Jenny Hedtke at 1-888-287-4741

b. Coverage will begin on the first of the month following BCBSMN receipt of the enrollment form

c. Payment mode - a monthly bill will be issued after completion of the enrollment process. First months premium is not due with the enrollment submission.