

## Idaho School Benefit Trust Health/Dental/Vision Enrollment Application

								ed Effect Number		e (subject to a	pproval by	the Plar	1)			
							□ PPO Wedical					☐ HSA Blue <sup>sM</sup> PPO				
							☐ Managed Care Medical POS				☐ HSA Blue <sup>sM</sup> POS					
						ПP	□ PPO Dental				☐ Tradi	tional	Dental			
						executation in the section of the se				□ Dental Blue Connect						
											□ Vision					
Please complete	each sectio	n of thi	s applicati	on i	n ink.											
Applicant Info	ormation	(Empl	oyee)		METERS OF STREET	of the state of th			C. C. S.		<b>公司自由基础</b>	THUM: TO				
Your Nama (first, initial, last)						Blue Cross ID No. (if currently enrolled)			Social Security	1875 MINISTER			□ Ma □ Fe			
Mailing Address							City, State, Zip Code			Phone Number						
Marital Status  Single Married Divorced Widowed	Name of Employer  Marsing School Dis			istric	Job Title				Email Address							
Dependent In	formation	(If you c	hoose not to e	nroll a	ill your eligible far	mily memb	ers, you	must comple	te a walve	r form.)						
List all eligible depender	nts you wish to en	oll, includin	g any child who	is und	ier the age of 26; o	r who is me	edically c	ertified as disa	bled and d	ependent on pare	nt for support	(copy of	certification red	quired).		
		Sociál Security Number		(	Relationship spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)		Height	Weight	Maje/Female	Type of E		e of Enrollmer	Enrollment		
Applicant/Employee				SELF					□ Male □ Female	Enroll in Medical						
For Managed Care	Plans Only	Name-of- PCP)	Primary Care Pl	nysicia	in (PCP) or PCP ID	Number (	For the h	ighest-benefit-	level, you n	ust-select-a-	Existing-P		Office Use (PCP)			
Dependent's Name (first, initial, lest)										□ Male □ Female	Enroll in Me Enroll in De	dical		QYes	ONo ONo	
For Managed Care Plans Only		Name-of-Primary-Gare Physician (PCP) or PCP ID No PCP)			) Number (	For the h	ighest benefit	level, you n	ust select a	Existing P	ationt?	Office Use (PCP)				
Dependent's Name (first, initial, last)										□ Male □ Female	Enroll in De	ntal		QYes	ONO ONO	
For Managed Care Plans Only		Name of PGP)	P <del>rimary Care Ph</del>	<del>vysicia</del>	n (PCP) or PCP ID	Number (I	For the h	ghest-benefit	level, you n	<del>ust select a</del>	Existing-P ©Yes-E		Office Use (PCP)			
Dep <mark>end</mark> ent's Name (first, Inilial, Iast)										□ Male □ Female		ntall		DYes	DNo DNo	
For Managed Care Plans Only		Name of I	Primary-Gare Ph	ysiela	n (PGP) or PCP ID	Number (f	For the hi	ghest benefit	level, you-n	ust soleet a	Existing P	<del>0141</del>	Office Use (PCP)			
Dependent's Name (first, initial, last)		Now of	Silmani Cara Ph	uslala	(DCD) or DCD ID	Number		sheet houseful		□ Male □ Female	Enroll in De Enroll in Vis	ntal lon,			ONo ONo	
For Managed Care Plans Only		Name-of Primary Care Physician (PCP) or PCP ID Nu PCP)				- Number-(i	Transition inglicative interest in the state of the state				Existing P ElYes C		Office Use (PCP)			
Dependent's Name (first, initial, last)										□Male □Female	Enroll in Me Enroll in De Enroll in Vis	nta)	meramerajae menamenajaean	Q Yes Q Yes Q Yes		
For Managed Care	Plans Only	Name of F	rimary Care Phy	eisian	(PCP) of PCP ID N	lumber (Fo	rthe high	est benefit leve	il, you must	select a PCP)	Existing P		Office Use (PCP)			
Type of Enroll	ment		CONTRACTOR ACTION IN STREET	( (m) (* 00)	<b>明本的 影响应信 计信仰 64-2</b>		Cha	nge Re	quest		Phillips and the sale				THE PERSON NAMED IN	
aalth Coverage Dental Coverage Vision Coverage  (check one) (check one)  (self-only □self only □self only  Self-and-speuse □self and spouse □self and spouse						Please indicate reason for change in current enrollment below:  Involuntary loss of group coverage Marriage Birth Adoption  Court order (copy of court order required)										
⊒ Self, spouse and depend					spouse and depen	ndents	Other									
O Self and one-dependent	Self-and-one-dependent										-					
OSelf and two or more dependents OSelf and two or more dependents					and two or more ndents		Date event occurred mm dd yy .									
lease read the reve		sign an	d date this	appl	lication.				T. BILINE					0	VER	
OR OFFICE USE ONLY  Group Number Subgroup Effective Date					REE MAN	Pian ID				ST THE	Class	manuscration of	Reason C	nde		
Second Minimal	Sandlooh	$\dashv$			М			D	T	v	<del>                                     </del>			2030/I G	-48	
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3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550 Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

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7.7	alth-Statement-(c	complete this healt	h statement If you	apply for cov	erage for yourself or a	family member aft	er-the original olig	jibility period.)	
ha	<del>ive yeu er any family i</del> 62 <del>Yes D No</del>	HANDER IELEG ON	ınıs application e	ver been adv	deed to have any surg	<del>Jical operation(s) i</del>	that you or any f	amlly-member-l	ave not yet
2, De	You or any family ma	mharlisted on this	annilection and	or frances	harata .				
	you or any family me gardiose of whether a Yes (2) No	physiclan or other	health care prof	er from any c essional has	<del>been consulted?</del> been consulted?	lments, Illnosses c	e <del>r other departur</del>	es frem good h	egith,
	ring the past 12 month escribed medication?	hs, have yeu or an	y family member	rlisted on this	s application received	l a-prescription-fer	-medication fron	ı a physkilan ər	taken any-
	<del>Yes □</del> Ne	Anhau Bata at ana 11 t							
⊕7	you or any family mo Yes □ No If pregna	antiwhat is the an	ticipated delivery	/-date?	· · · · · · · · · · · · · · · · · · ·		/		
5. Ha∙ ¥⊑	ve yeu er any family n ∕es⊖No	1-no-betail-rédmen	<del>his application e</del>	ver been refu	ontser beusal restric	ted health insurar	noe-coverage?		
6. Hav ⊡ Y	/o-yeu-or-any-family-m ′os-⊡-No	ember listed on the	is application be	əən həspitaliz	ed during the last 5	<del>years?</del>			
7. \4/iti	in the past two years	, have you or any	<del>Ypamber of your</del>	family-been	treated for back/joint	-disorder?			
WY	<del>01/12/36</del>								
<del>or n</del>	re you' or any family m shol/drug use or abuse ervous disorders or r es 🗗 No	ember listed on ti encer, heart pro espiratory disord	nls application e obtern/disorder, ors?	ver had, bee dlabetes, dig	n-told he or she had, estive disorder, imm	been coanseled une disorder, rena	<del>or treated for a</del> r HAldney diseas:	iy of the fellowl e, strokes, men	<del>ng:</del> tal-
			`						
f you c	hecked YES to any qu	uestion-above, ple	ese provide deta	ils bèlow (pie	ese uso extra paper	if-nocossary);			
ltom-		Afo.J.	Name-of Disca er-Condi	se, Symptom.			l4∕as-	Druge - Include Type or Name,	
No,	Percon Affected	Year	Include Type o	of Treatment	Name-of-lospital at Number of Days	nd- Date-Last- Treated	Recovery- Complete?	Desage, Strength and Duration	Name et Physician
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8-or o	y person-listed on this ider}? □ No □ Yes-If y	<del>-application used ( res, list-names bel</del>	a-tobacco produc ow:	on average	-four-or-more-times a	week within no lo	ng <del>or than the p</del> a	ist six menths (i	anyone age
			/		<del></del>	<del></del>			
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urre	nt/Prior Coverag	8 For Coordinati	on of Repolits n	lassa sampla	ifo the goatten halou	· · · · · · · · · · · · · · · · · · ·			
you o	any of your family pla	embers have other	medicai and/or	dental cover	ere? [] Yes [] No	- Use extra paper-	f-nocessary).	<del>-</del>	
ordinat provide	ling your benefity cou	ld reduce the amo	ount you owe a	provider. For	proper coordination	of benefits please court documentat	complete the sion that shows	section below, ! who is respons	f coverage :
Other	nt(s)' health care cover Carrier Information: Name, Policy Number,	ago so trat irie ta	anier Gan determ	1	overage is pranally. O	Se extra paper if I	1ecessary.	1	
	Phone Number	Policyhol	der Name	Names of Self a	f Covered Members: and Dependent(s)	Start Date (mm/dd/yy)	End Date (mm/dd/yy)	Type of Coverage	VViil <u>this</u> coverage continue?
	<del>/</del>							D Medical Dental	□Yes □ No
/	<u> </u>		<del></del>					☐ Medical ☐ Delital	□Yes □ No
_							-	☐ Medical	□Yes □No
			,					☐ Medical ☐ Dental	□Yes □No
							<del></del>	☐ Medical	□Yes
								Denta!	□ No

Disability Information	
Ara you or any of your dependents currently disabled? ## YES ## PNO	THE RESERVE TO SERVE THE PROPERTY OF THE PROPE
	Nature of Disability
Name of Disabled Person	Physician's Name Physician's Phone Number
Date of Disability	Physician's Address
Statement of Understanding	The state of the s
By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:  I agree to abide by all of the terms and conditions of the Plan.  No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.  Plan Administrator may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.  Plan Administrator may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.	<ul> <li>My employer's summary plan description is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Plan Administrator.</li> <li>I agree that a facsimile or photocopy of my signature will serve the same as an original.</li> <li>I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.</li> </ul>
If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Plan Administrator.	X Applicant's Signature
I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more linformation about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at bcidaho.com.	Date