

# Large Group Member Application for Health, Dental and Vision Insurance



Please be sure ALL information below is complete to avoid delays in processing.

Please print clearly using blue or black ink or type information.

Section 1 Employer Information (To be completed by plan administrator.)			
Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number	Dept. number		
Choose one: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> COBRA <input type="checkbox"/> Loss of coverage (HIPAA Certificate of Creditable Coverage required) <input type="checkbox"/> Other _____		<b>or</b>	Add dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent  Date of event (mm/dd/yyyy) _____ <b>(Must add within 30 days of marriage, birth, or adoption of dependent.)</b>
Section 2 Employee Information			
Last name	Suffix	First name	M.I.
Home address (street/apartment number)		City/town	State ZIP code
Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)			
Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
Home phone number		Cell phone number	
E-mail address			
Marital status (please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Common law <input type="checkbox"/> Other _____			
What is your primary language spoken? _____			
Race (please check one) <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or <b>other</b> Pacific Islander <input type="checkbox"/> White			
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	

\*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See [www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html)

**Section 3** Health Plan Options

Plan type

- Medical:     Enrollee only     Enrollee and spouse     Enrollee and child(ren)  
                    Enrollee, spouse and child(ren)  
 Dental:     Enrollee only     Enrollee and spouse     Enrollee and child(ren)  
                    Enrollee, spouse and child(ren)  
 Vision:     Enrollee only     Enrollee and spouse     Enrollee and child(ren)  
                    Enrollee, spouse and child(ren)

What product(s) are you selecting?

- |  |  |
|--|--|
| <input type="checkbox"/> BlueCHiP _____                              | <input type="checkbox"/> VantageBlue _____                           |
| <input type="checkbox"/> BlueSolutions for HSA _____                 | <input type="checkbox"/> VantageBlue SelectRI _____                  |
| <input type="checkbox"/> Classic (if available) _____                | <input type="checkbox"/> Blue Cross Dental _____                     |
| <input type="checkbox"/> HealthMate Coast-to-Coast _____             | <input type="checkbox"/> Blue Cross Vision _____                     |
| <input type="checkbox"/> HealthMate Coast-to-Coast Deductible _____  | <input type="checkbox"/> Vantage Blue with Dental _____              |
| <input type="checkbox"/> HealthMate Coast-to-Coast Coinsurance _____ | <input type="checkbox"/> Healthmate Coast-to-Coast with Dental _____ |
|  | <input type="checkbox"/> Pharmacy 4-Tier _____                       |
|  | <input type="checkbox"/> Pharmacy 5-Tier _____                       |
|  | <input type="checkbox"/> Other _____                                 |

**Section 4** Spouse Information

Last name	Suffix	First name	M.I.
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Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
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Home phone number	Cell phone number
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E-mail address

Race (please check one)

Prefer not to answer     American Indian or Alaska Native     Asian     Black or African American  
 Hispanic or Latino     Native Hawaiian or **other** Pacific Islander     White

Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)

Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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<b>Section 5</b> Dependent Information (If necessary, please attach dependent addendum.)				
<b>Dependent #1</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<b>Dependent #2</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<b>Dependent #3</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<b>Dependent #4</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<input type="checkbox"/> <b>Check here if Group Dependent Addendum form will be attached.</b>				

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**Section 6 Other Insurance**

Are you or any of your dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other insurance company and name(s) of covered person(s): <b>Covered person 1</b> _____ Insurance company _____ Member ID #1 _____ <b>Covered person 2</b> _____ Insurance company _____ Member ID #2 _____
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What is the name of your prior health insurance carrier? _____ _____	What was the date of termination? (mm/dd/yyyy) _____ If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.
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Is anyone named in this application eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of eligible person _____
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Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	Retired date (if applicable) _____	Medicare number _____ - _____ - _____
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Effective dates: (mm/dd/yyyy)  
 Part A (hospital): \_\_\_\_\_ Part B (medical): \_\_\_\_\_

By signing this form, I certify the information is true and complete to the best of my knowledge.

SIGN HERE 	_____ Signature of applicant	_____ Date
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Application rec'd date _____ ID # _____
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