Group Member Application for Health and Dental Insurance

Blue Cross Blue Shield of Rhode Island

Please be sure ALL information below is complete to avoid delays in processing.
Please **print clearly** using blue or black ink.

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:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (HIPAA Certificate of Creditable Coverage required)
- ☐ Other _____

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) _____
(Must add within 31 days of marriage, birth, or adoption of dependent.)

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 ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number	Best time to call ☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7 p.m.

E-mail address

Marital status (please check one)
- ☐ Single ☐ Married ☐ Divorced
- ☐ Common law ☐ Other _____

Communication preference (please check one)
- ☐ U.S. mail ☐ E-mail
- ☐ Home phone ☐ Cell phone

Race (please check one)
- ☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
- ☐ Multiracial ☐ Native Hawaiian and other Pacific Islander ☐ White

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

Are you a current patient? ☐ Yes ☐ 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.hhs.gov/MandatoryInsRep/

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)

What product(s) are you selecting?

☐ Classic (if available) _____
☐ HealthMate Coast-to-Coast _____
☐ HealthMate Coast-to-Coast Coinsurance _____
☐ HealthMate Coast-to-Coast Deductible _____
☐ BlueCHiP _____
☐ Blue Cross Dental _____
☐ BlueSolutions for HSA _____
☐ BlueSolutions SelectRI _____
☐ VantageBlue _____
☐ VantageBlue SelectRI _____

Section 4 Spouse Information

Last name	Suffix	First name	M.I.

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number	Best time to call ☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7 p.m.

E-mail address

Communication preference (please check one)
☐ U.S. mail ☐ E-mail ☐ Home phone ☐ Cell phone

Race (please check one)
☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian and other Pacific Islander ☐ White

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

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 5 Dependent Information (If necessary, please attach dependent addendum.)

Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ 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 (**mandatory** for BlueCHiP plans)

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ 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 (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ 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 (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ 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 (**mandatory** for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

☐ **Check here if Group Dependent Addendum form will be attached.**

Section 6 Other Insurance

Are you or any of your dependents covered by other insurance? ☐ Yes ☐ No	Name of other insurance company and name(s) of covered person(s):
	Covered person 1 _____
	Insurance company _____
	Member ID #1 _____
	Covered person 2 _____
	Insurance company _____
	Member ID #2 _____

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

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.
Is anyone named in this application eligible for Medicare? ☐ Yes ☐ No	If yes, name of eligible person _____

Is the eligible person ☐ Over 65 ☐ Disabled	Retired date (if applicable) _____	Medicare number ___-___-___-____

Effective dates: (mm/dd/yyyy)
Part A (hospital): _____ Part B (medical): _____

Section 7 Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:
- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

SIGN HERE

_____
Signature of applicant Date

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island
www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

11/12 IER-12497 • 8451