

## INSTRUCTIONS:

## **MEMBERSHIP APPLICATION**

(Fifty-One or More Eligible Employees)

1. PRINT HARD WITH BLACK BALL-POINT PEN OR TYPE.

2. COMPLETE AND SIGN APPLICATION.

	3. BEOLOIII O	OURDINATED	IIEAEIII I	I LAIT (BLOLO	· · · / LIVINO	LLLLO. OLLLO	71 71 01	TONEA	OIT WILWIDLIN	IIV III LINIC	20-30.		
(A1) GROUP (A2) SUBGR	P (A3) CK (A4) LI	D		,									
							APPL	APPLICATION RECEIVED DATE					
1 PLAN DESIRED: HEALTHMATE C TO C CLASSIC BLUECHIP DENTAL BENEFITS 1 OTHER DINDIVIDUAL FAMILY TWO PARTY 2 APPLICATION TYPE: NEW CHANGE TRANSFER													
Covering: INDIVIDUAL	/					·	I -						
3 EMPLOYER (GROUP) NAME	4 GROUP NUMBER			(5)	OF COVERAGE			FOR MEMBERSHIP USE ONLY					
								CONTRACT TYPE PACKAGE					
7 LAST NAME 8 FIRST	(JR, MD, ETC) MA		ALE 🛄	(12)	SINGLE MARRIED !  WID SEP DIV  COMMON LAW		13) BII MONTH	BIRTHDATE YEAR					
			MALE 🗖										
(14) RESIDENCE ADDRESS STREET, I	15) ADDITIONAL ADDRESS (APT., BLDG., ETC			., ETC.)	C.) (16) CITY			STATE (18) ZIP					
HOME TELEPHONE (with area code)	(21) OCCUPATION			22	EMPLOYEE NUMBER			PRIMARY LANGUAGE SPOKEN					
24)	(25) (26)		(27)		28 ** <u>MA</u>	NDATORY FOR CHIP COVERAGE	(29)	(30)	(31)				
NAME (LAST) (FIRST) (MI	) BIRTHDATE SEX MO. DAY YR.	RELATIONSHIP	SEC	CIAL URITY MBER	PER	RSONAL CARE (SICIAN (PCP)	ARE YOU A CURRENT PATIENT?	PCP NUMBER	IF STUDENT NAME OF CO		Admission Mo. Yr.		
Please Do Not Write In Shaded Area.	SUBSCRIBER			FIRST NAME	LAST NAME YES			Please Do Not Write In Shaded Areas.					
	/ / 🗀 M	SPOUSE			FIRST NAME	LAST NAME	☐ YES ☐ NO						
	/ / 🗀 M	DEPENDENT			FIRST NAME	LAST NAME	☐ YES ☐ NO						
	/ / 🗀 M	DEPENDENT	NDENT			LAST NAME	☐ YES ☐ NO						
	/ / 🗀 M	DEPENDENT	ENDENT			LAST NAME	☐ YES ☐ NO						
	/ / 🗀 M	DEPENDENT	ENT FIRS			LAST NAME	☐ YES ☐ NO						
						ATION CANNOT							
PROCESSED WITHOUT SELECTION OF PCP													
NAME OF POLICY HOLDER WITH OTHER INSURANCE:  (36) NAME					AND ADDRESS OF OTHER INSURANCE CO./OTHER PLAN								
37 IS ANYONE NAMED IN THIS APPLICATION ELIGIBLE FOR MEDICARE COVERAGE?	ME OF ELIGIBLE	PERSON	38 ELIGIE	REASON FOR ELIGIBILITY  OVER 65  REASON FOR 39  MEDIC 5FFEC MO		ARE A (HOSPITAL) (		MEDICARE B (MEDICAL) EFFECTIVE DATE MO DAY YR					
NAME LINDER WHICH CURREN		☐ DIS	SABILITY										
CURRENT GROUP NO. ARE YOUT TRANSFERDING FROM ANY OF THE FOULOWING?													
F O		(44)	BLUE CRO	OSS AND BLUE	SHIELD	☐ OTHER							
CHANGE FROM SINGLE PLAN TO FAMILY PLAN						CHANGE FROM FAMILY PLAN TO SINGLE PLAN							
□ MARRIAGE DATE OF MARRIAGE SPOUSE'S FORMER LAST NAME						(49) ☐ DIVORCE (50) DATE OF CHANGE							
ADDITION OF DEPENDENTS CANCELLATION OF DEPENDENTS (Complete Dependent Section above)						☐ DEATH OF SPOUSE / / ☐ SEPARATED ☐ OTHER (specify)							
↑ NAME CHANGE FORMER NAME:  ADDRESS CHANGE (complete address section above)					т	DATE OF ENTRY			DATE OF DISCHARGE				
hereby authorize any physician, hospital, ot	her medical facility or pr	ovider to release	to Blue Cro	ss & Blue Shield	d of Rhode Is	land any and all r	ecords, op	oinions, rep	orts, x-rays, la	boratory te	sts,		
analysis or other information of any kind relat of Rhode Island. Blue Cross & Blue Shield o to the administration of Blue Cross & Blue Sh	of Rhode Island may use	this information	for purpose	s of claims payn	nent, case ma	anagement, coor	dination of	benefits, a	and other purpo	Cross & Blu oses directl	ue Shield y related		
I certify the information is true and co	omplete to the best of	of my knowled	ge.			. ,							
SIGNATURE						DATE							
Employee Copy may be used as	s temporary evide	ence of cove	rage for	30 days fro	m the da	te below if a	uthorize	ed by e	mployer.				
EMPLOYER VERIFICATION:						DATE							

Yellow - Employer

Pink - Employee's Copy

Gold - Marketing

White - Membership Dept.

IER