

Group Member Application for Health and Dental Insurance



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 BARRINGTON PUBLIC SCHOOLS		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number 336	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 _____		or	Add dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> 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
Home address (street/apartment number)		City/town	State
M.I.			
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	
Marital status (please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Common law <input type="checkbox"/> Other _____			
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
Section 3 Health Plan Options			
Plan type			
<input type="checkbox"/> Medical: <input type="checkbox"/> Enrollee only <input type="checkbox"/> Enrollee and spouse <input type="checkbox"/> Enrollee and child(ren) <input type="checkbox"/> Enrollee, spouse and child(ren)			
 <input type="checkbox"/> Dental: <input type="checkbox"/> Enrollee only <input type="checkbox"/> Enrollee and spouse <input type="checkbox"/> Enrollee and child(ren) <input type="checkbox"/> Enrollee, spouse and child(ren) 			

*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 product(s) are you selecting?

- HealthMate Coast-to-Coast _____
 HealthMate Coast-to-Coast HDHP _____
 BlueSolutions for HRA _____
 BlueSolutions for HSA _____

- BlueCHIP _____
 Classic _____
 Dental _____

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

Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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Section 5 Dependent Information (If necessary, please attach dependent addendum.)

Dependent #1 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
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Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*
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Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHIP plans)

Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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Dependent #2 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
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Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*
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Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHIP plans)

Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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Dependent #3 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)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
Dependent #4 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)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of eligible person _____		
Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	Retired date (if applicable) _____	Medicare number ____ - ____ - ____ - ____		
Effective dates: (mm/dd/yyyy) Part A (hospital): _____ Part B (medical): _____				

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Group Dependent Addendum



Please complete the following when you have more than four dependents and attach it to the Group Member Application.

Employer group name	Group number	Dept. number	
Employee name	Social Security number (xxx-xx-xxxx)*		
Phone number	Effective date (mm/dd/yyyy)		
Dependent Information			
Dependent #5 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)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #6 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)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #7 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)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		

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Dependent #8 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)*	
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	

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.



Signature of applicant

Date

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Application rec'd date _____ ID # _____

