

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		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 _____		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	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		
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?	
<input type="checkbox"/> HealthMate Coast-to-Coast _____	<input type="checkbox"/> BlueCHiP _____
<input type="checkbox"/> HealthMate Coast-to-Coast HDHP _____	<input type="checkbox"/> Classic _____
<input type="checkbox"/> BlueSolutions for HRA _____	<input type="checkbox"/> Dental _____
<input type="checkbox"/> BlueSolutions for HSA _____	

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 <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	
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 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
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 #2 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 #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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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 # _____



500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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