

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		Best time to call <input type="checkbox"/> 9 a.m. to noon <input type="checkbox"/> noon to 4 p.m. <input type="checkbox"/> 4 p.m. to 7 p.m.	
E-mail address					
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 _____			Communication preference (please check one) <input type="checkbox"/> U.S. mail <input type="checkbox"/> E-mail <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone		
Race (please check one) <input type="checkbox"/> American Indian and Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian and other Pacific Islander <input type="checkbox"/> White					
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			

*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) _____ Blue Cross Dental _____
- HealthMate Coast-to-Coast _____ BlueSolutions for HSA _____
- HealthMate Coast-to-Coast Coinsurance _____ BlueSolutions SelectRI _____
- HealthMate Coast-to-Coast Deductible _____ VantageBlue _____
- BlueCHiP _____ VantageBlue SelectRI _____

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	Best time to call <input type="checkbox"/> 9 a.m. to noon <input type="checkbox"/> noon to 4 p.m. <input type="checkbox"/> 4 p.m. to 7 p.m.
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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? <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)*	E-mail address
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Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans)

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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)*	E-mail address	
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 #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)*	E-mail address	
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)*	E-mail address	
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 _____		

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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): _____

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.



 Signature of applicant Date

Application rec'd date _____ ID # _____

