

# 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		
<b>Choose one:</b> <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 _____		<b>or</b>	<b>Add dependent(s)</b> <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 ( <b>mandatory</b> 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"/> <b>Medical:</b> <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"/> <b>Dental:</b> <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/](http://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.)**

<b>Dependent #1</b> 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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<b>Dependent #2</b> 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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<b>Dependent #3</b> 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 ( <b>mandatory</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<b>Dependent #4</b> 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 ( <b>mandatory</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<input type="checkbox"/> <b>Check here if Group Dependent Addendum form will be attached.</b>				
<b>Section 6 Other Insurance</b>				
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.



\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

Application rec'd date \_\_\_\_\_ ID # \_\_\_\_\_



www.BCBSRI.com

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