

Large Group Member Application for Health, Dental and Vision 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 _____		<i>or</i> 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.			
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)*
Home phone number		What is your primary language spoken?	
Cell phone number			
E-mail address			
Marital status (please check one)			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Common law <input type="checkbox"/> Other _____			
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 and VantageBlue Select 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.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

**If you choose the VantageBlue Select plan, you must select a Primary Care Physician (PCP) and other healthcare providers (including hospitals, specialists, labs, and durable medical equipment suppliers) from the VantageBlue Select network in order to get the lowest out-of-pocket healthcare costs (e.g., copayments and coinsurance). Providers in the VantageBlue Select network can be found at www.BCBSRI.com/VBSelectProviders or in the Find A Doctor tool on BCBSRI.com. If you do not seek services from a VantageBlue Select network provider or receive a network referral you will be responsible for the applicable higher out-of-network cost sharing.

Section 3 Health Plan Options

Plan type

- Medical: Enrollee only
 Enrollee, spouse and/or child(ren)

What product(s) are you selecting?

- HealthMate Coast-to-Coast
 HealthMate Coast-to-Coast Deductible _____

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	
E-mail address			
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 and VantageBlue Select 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
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 and VantageBlue Select 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)*		E-mail address	
**Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP and VantageBlue Select 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 and VantageBlue Select 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 and VantageBlue Select 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.					

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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	_____
	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.
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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,

- 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.
- I certify the information is true and complete to the best of my knowledge.

IF VantageBlue Select is chosen: I understand and acknowledge that in choosing the VantageBlue Select plan, I have chosen a plan with a specified network of providers and that I have reviewed the list of primary care physicians, hospitals, obstetrician/gynecologists and pediatricians in the network at www.BCBSRI.com/VBSelectProviders. Although I may choose to go to providers outside of the network, in order to get the lowest out-of-pocket costs, I have to get services from providers (including hospitals, specialists, labs, and durable medical equipment suppliers) from the VantageBlue Select network. If I get a referral to see an out-of-network provider, my out-of-pocket costs will be the same as if I go to a provider in the VantageBlue Select network. I understand that if I do not get a referral to see an out-of-network provider, other than for emergency care, my out-of-pocket costs will be higher.

SIGN HERE 	_____ Signature of applicant	_____ Date
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Application rec'd date _____ ID # _____

