Large Group Member Application for Health, Dental and Vision Insurance

Blue Cross Blue Shield of Rhode Island

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:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (HIPAA Certificate of Creditable Coverage required)
- ☐ Other _____

or

Add dependent(s)
- ☐ Spouse
- ☐ 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 ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

E-mail address

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Civil Union ☐ Common law ☐ Other _____

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 and VantageBlue Select plans)

Are you a current patient? ☐ Yes ☐ 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 ☐ M ☐ 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)

☐ 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 and VantageBlue Select plans)

Are you a current patient? ☐ Yes ☐ 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

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Section 5 Dependent Information (If necessary, please attach dependent addendum.)			
Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
☐ **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?
☐ Yes ☐ 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?
☐ Yes ☐ No

If yes, name of eligible person

_____

Is the eligible person
☐ Over 65 ☐ Disabled

Retired date (if applicable)

_____

Medicare number

__ __ __ - __ __ - __ __ __ __ - _____

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.

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

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island
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