Small Group Member Application for Health and Dental 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

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

Primary care physician (PCP) name, street, city/town, state, and ZIP code

Are you a current patient? ☐ Yes ☐ No	Provider ID

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)

*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?

☐ VantageBlue_____

☐ HealthMate Coast-to-Coast 2000/4000_____

☐ BlueSolutions for HSA_____

☐ Dental_____

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

Primary care physician (PCP) name, street, city/town, state and ZIP code

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 5 Dependent Information (If necessary, please attach dependent addendum.)

Dependent #1 Last name	First name	M.I.	Relationship ☐ Son ☐ 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

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #2 Last name	First name	M.I.	Relationship ☐ Son ☐ 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

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.hhs.gov/MandatoryInsRep/

Dependent #3 Last name	First name	M.I.	Relationship ☐ Son ☐ 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			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

Dependent #4 Last name	First name	M.I.	Relationship ☐ Son ☐ 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			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

☐ **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? ☐ 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): _____

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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 #_____

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