INSTRUCTIONS:
1. PRINT HARD WITH BLACK BALL-POINT PEN OR TYPE.
2. COMPLETE AND SIGN APPLICATION.
3. **BLUECHiP COORDINATED HEALTH PLAN (BLUECHiP) ENROLLEES: SELECT A PCP FOR EACH MEMBER IN ITEMS 28-30.**

MEMBERSHIP APPLICATION
(Fifty-One or More Eligible Employees)

DO NOT WRITE IN THIS AREA: (A1) GROUP | (A2) SUBGRP | (A3) CK | (A4) LID | APPLICATION RECEIVED DATE

(1) **PLAN DESIRED:** ❑ **HEALTHMATE C TO C** ❑ **CLASSIC** ❑ **BLUECHIP** ❑ **OTHER** ____
Covering: ❑ INDIVIDUAL ❑ FAMILY ❑ TWO PARTY

❑ **DENTAL BENEFITS**
❑ INDIVIDUAL ❑ FAMILY ❑ TWO PARTY

(2) APPLICATION TYPE: ❑ NEW ❑ CHANGE ❑ TRANSFER

(3) EMPLOYER (GROUP) NAME | (4) GROUP NUMBER | (5) EFF. DATE OF COVERAGE | (6) **FOR MEMBERSHIP USE ONLY** — CONTRACT TYPE | PACKAGE

(7) LAST NAME | (8) FIRST | (9) INITIAL | (10) TITLE (JR, MD, ETC) | (11) MALE ❑ FEMALE ❑ | (12) CHECK MARITAL STATUS: SINGLE ❑ MARRIED ❑ WID ❑ SEP ❑ DIV ❑ COMMON LAW ❑ | (13) BIRTHDATE: MONTH | DAY | YEAR

(14) RESIDENCE ADDRESS STREET, BOX, RT. NO. | (15) ADDITIONAL ADDRESS (APT., BLDG., ETC.) | (16) CITY | (17) STATE | (18) ZIP

(19) HOME TELEPHONE (with area code) ( ) | (20) DATE OF HIRE / / | (21) OCCUPATION | (22) EMPLOYEE NUMBER | (23) PRIMARY LANGUAGE SPOKEN

(24) NAME (LAST) (FIRST) (MI)	(25) BIRTHDATE MO. DAY YR.	(26) SEX	RELATIONSHIP	(27) SOCIAL SECURITY NUMBER	(28) **MANDATORY FOR BLUECHIP COVERAGE** PERSONAL CARE PHYSICIAN (PCP)	(29) ARE YOU A CURRENT PATIENT?	(30) PCP NUMBER	(31) IF STUDENT NAME OF COLLEGE	Admission Mo. Yr.
Please Do Not Write In Shaded Area.			SUBSCRIBER		FIRST NAME LAST NAME	❑ YES ❑ NO		**Please Do Not Write In Shaded Areas.**	
	/ /	❑ M ❑ F	SPOUSE		FIRST NAME LAST NAME	❑ YES ❑ NO			
	/ /	❑ M ❑ F	DEPENDENT		FIRST NAME LAST NAME	❑ YES ❑ NO			
	/ /	❑ M ❑ F	DEPENDENT		FIRST NAME LAST NAME	❑ YES ❑ NO			
	/ /	❑ M ❑ F	DEPENDENT		FIRST NAME LAST NAME	❑ YES ❑ NO			
	/ /	❑ M ❑ F	DEPENDENT		FIRST NAME LAST NAME	❑ YES ❑ NO			

**APPLICATION CANNOT BE COMPLETELY PROCESSED WITHOUT SELECTION OF PCP

Other Insurance Information

(32) IF YOU OR ANY OF YOUR DEPENDENTS ARE ENROLLED IN ANOTHER INSURANCE PLAN, IS COVERAGE FOR HEALTH ❑ DENTAL ❑ | (33) RELATIONSHIP: | (34) POLICY/CONTRACT #

(35) NAME OF POLICY HOLDER WITH OTHER INSURANCE: | (36) NAME AND ADDRESS OF OTHER INSURANCE CO./OTHER PLAN

(37) IS ANYONE NAMED IN THIS APPLICATION ELIGIBLE FOR MEDICARE COVERAGE? ❑ YES → NAME OF ELIGIBLE PERSON ❑ NO | (38) REASON FOR ELIGIBILITY ❑ OVER 65 ❑ DISABILITY | (39) MEDICARE A (HOSPITAL) EFFECTIVE DATE MO DAY YR | (40) MEDICARE B (MEDICAL) EFFECTIVE DATE MO DAY YR

TRANSFER

(41) NAME UNDER WHICH CURRENT CONTRACT IS LISTED | (42) CURRENT IDENTIFICATION NO.

(43) CURRENT GROUP NO. | (44) ARE YOU TRANSFERRING FROM ANY OF THE FOLLOWING? ❑ BLUE CROSS AND BLUE SHIELD ❑ OTHER

CHANGE

CHANGE FROM SINGLE PLAN TO FAMILY PLAN

(45) ❑ MARRIAGE | DATE OF MARRIAGE | SPOUSE'S FORMER LAST NAME

(46) ❑ ADDITION OF DEPENDENTS (Complete Dependent Section above) | ❑ CANCELLATION OF DEPENDENTS

CHANGE FROM FAMILY PLAN TO SINGLE PLAN

(49) ❑ DIVORCE ❑ DEATH OF SPOUSE ❑ SEPARATED ❑ OTHER (specify) | (50) DATE OF CHANGE / /

(47) ❑ NAME CHANGE FORMER NAME: ❑ ADDRESS CHANGE (complete address section above) | (48) ❑ MILITARY REINSTATEMENT | DATE OF ENTRY / / | DATE OF DISCHARGE / /

I hereby authorize any physician, hospital, other medical facility or provider to release to Blue Cross & Blue Shield of Rhode Island any and all records, opinions, reports, x-rays, laboratory tests, analysis or other information of any kind relating to myself or my minor dependents which is requested or received while such persons are covered by health insurance from Blue Cross & Blue Shield of Rhode Island. Blue Cross & Blue Shield of Rhode Island may use this information for purposes of claims payment, case management, coordination of benefits, and other purposes directly related to the administration of Blue Cross & Blue Shield of Rhode Island. This authorization shall expire two (2) years from the issue date of this policy, unless sooner revoked.

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

SIGNATURE ____ **DATE** ____

Employee Copy may be used as temporary evidence of coverage for 30 days from the date below if authorized by employer.

EMPLOYER VERIFICATION: ____ DATE ____

White - Membership Dept. Gold - Marketing Yellow - Employer Pink - Employee's Copy

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