Add Dependent Form
Plans for Individuals and Families

For plans purchased directly from BCBSRI (not through an employer)

Please complete the following when you are adding dependents to your existing BCBSRI policy, including signing the application. This Add Dependent form shall be deemed a part of the Medical and Dental Plan Application for Individuals and Families ("the Application").

Policyholder's name _____ Phone number _____

BCBSRI Medical ID # _____ BCBSRI Dental ID # _____

Requested effective date ___ / ___ / _____

Section 1 Spouse or Domestic Partner Information (complete if adding a spouse or domestic partner)

First name_____M.I._____ Last name_____ Suffix_____

Marital status (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Common Law ☐ Civil Union ☐ Domestic Partner ☐ Widow/er

Coverage applied for: ☐ Medical ☐ Dental

Home address (if different from applicant) _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ M ☐ F

Social Security number[1] _____

Home phone number _____ Cell phone number _____

Email address _____

What is your race and/or ethnicity? (**select all that apply**)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Portuguese ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Other ☐ Prefer not to say

Use your BCBSRI member account to add/update demographic information. Visit **bcbsri.com** to register or log in.

Primary care provider (PCP) (**Required**): First name _____ Last name _____

You must select a PCP for yourself and anyone on your medical plan, otherwise your enrollment may be delayed and your benefits may be reduced.

National Provider ID (NPI)_____ (Find your PCP's NPI in their profile in the Find Care tool on bcbsri.com.)

PCP address _____ City/town _____ State _____ ZIP code _____

Is spouse/domestic partner a current patient of the PCP listed above? ☐ Yes ☐ No

[1]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-Non-Group-Health-Plans/Overview.html

Please remember to sign this application on the last page.

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Section 2 Dependent Information

Dependent

First name _____ M.I._____ Last name _____ Suffix_____

Sex assigned at birth ☐ M ☐ F Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social Security number[1] _____

E-mail address _____

Primary care provider (PCP) (**Required**): First name _____ Last name _____

NPI#_____ PCP address _____

City/town _____ State _____ ZIP code _____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

Dependent

First name _____ M.I._____ Last name _____ Suffix_____

Sex assigned at birth ☐ M ☐ F Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social Security number[1] _____

E-mail address _____

Primary care provider (PCP) (**Required**): First name _____ Last name _____

NPI#_____ PCP address _____

City/town _____ State _____ ZIP code _____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

Dependent

First name _____ M.I._____ Last name _____ Suffix_____

Sex assigned at birth ☐ M ☐ F Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social Security number[1] _____

E-mail address _____

Primary care provider (PCP) (**Required**): First name _____ Last name _____

NPI#_____ PCP address _____

City/town _____ State _____ ZIP code _____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

[1]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-Non-Group-Health-Plans/Overview.html

Please remember to sign this application on the last page.

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Section 3 Please select the reason you are adding dependent(s) to your coverage

☐ Open enrollment

☐ Loss of minimum essential coverage

If prior coverage was NOT with BCBSRI, please attach evidence of prior coverage showing coverage end date.

☐ Marriage, birth, or adoption

☐ Pregnancy

☐ Permanent move to Rhode Island

☐ Loss of eligibility for other coverage due to the policyholder's death, loss of employment or reduction of hours, divorce, or entitlement to Medicare; the employer filing for Chapter 11 bankruptcy; or the child turning 26

☐ New citizen or no longer incarcerated

☐ Change of eligibility for coverage or payment assistance underMedicaid or CHiP (RIteCare)

☐ Enrollment error, misrepresentation, misconduct, or inaction of an Exchange, or non-Exchange entity providing enrollment assistance

☐ Material contract violation by another plan

☐ Newly becoming eligible for an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)

Name of Employer_____

Name of ICHRA Vendor_____

☐ Newly eligible or ineligible for premium tax credits or cost-sharing reductions

☐ Gains or maintains status as an Indian, or dependent of an Indian, as defined by federal law

☐ Exceptional circumstances, including natural disasters, medical emergencies, and other circumstances that reasonably prevented enrollment

Section 4 Dental Direct Disclosure Statement

- A 12-month waiting period applies to periodontal services, oral surgery, crowns, and prosthodontics on some plans.
- You may be eligible to waive any applicable waiting periods for a dental plan if you've had equal or substantially similar prior coverage for at least 12 months; proof of equal or substantially similar prior coverage is provided within 60 days of the effective date of this dental plan. Your previous dental plan must have terminated within 60 days of the effective date of the new dental application with Blue Cross & Blue Shield of Rhode Island Dental.

Please note: *Waiting periods do not apply to members under the age of 19 enrolling in a Qualified Dental Plan. If you terminate coverage and then re-apply, the waiting periods listed above will apply without accounting for your prior coverage.*

Section 5 Terms, Conditions, and Signature

By signing this form, I acknowledge and agree that:

- I understand the medical and dental plan benefits I have selected, including the deductible benefit maximums and out-of-pocket maximums, if applicable.
- This change will not apply until the coverage is made effective by BCBSRI.
- The medical and/or dental plan selected shall apply to me and all enrolled dependents.
- I am responsible for sharing benefit information with my enrolled family members covered under this policy.
- I certify that I have read the above statements or that they have been read to me, and that the statements herein are true and complete to the best of my knowledge and belief.
- This application may be signed electronically through Docusign only, and I agree that the electronic signature created by Docusign is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Please remember to sign this application on the last page.

continued ➤

SIGN HERE ☞

Signature of policyholder or parent/guardian *if policyholder is under 18 years of age* Date

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURE

Section 6 Contact Information

Please submit your application by using one of the methods below:

- Email to: IndividualEnrollmentIntake@bcbsri.org
- Fax to: (401) 459-5378
- Mail to: Blue Cross & Blue Shield of Rhode Island
  Attn: Individual Sales Department
  500 Exchange Street
  Providence, Rhode Island 02903-2699

Blue Cross Blue Shield of Rhode Island

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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