Blue Cross Blue Shield of Rhode Island

Medical and Dental Plan Application for Individuals and Families

Please be sure to complete ALL information below, including signing the application, to avoid delays in processing. **Please print clearly using blue or black ink**. Save time! Apply online on bcbsri.com/individual/shop

Section 1 Applicant Information

First name _____ M.I. _____ Last name _____ Suffix _____

Home address _____

City/town _____ State _____ ZIP code _____

Mailing address (if different from home address) _____

City/town _____ State _____ ZIP code _____

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

Social Security number[1] _____ Current BCBSRI ID _____

Home phone number _____ Cell phone number _____

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

What is your primary language spoken? _____ 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 for medical coverage**):

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) # _____ PCP Address _____

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

City/town _____ State _____ ZIP code _____

Are you 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

Section 2 Medical and Dental Plan Options

Choose a **medical** plan type: ☐ Individual ☐ Family
Requested medical effective date (mm/dd/yyyy): ____ / ____ / _____

Medical coverage applied for:

VantageBlue Direct	BlueSolutions for HSA Direct	BlueCHiP Direct	BasicBlue Direct
☐ $950/1,900 Platinum	☐ $1,900/3,800 Gold	☐ $2,300/4,600 Gold	☐ $2,500/5,000 Gold
☐ $1,600/3,200 Gold	☐ $4,100/8,200 Silver	☐ $5,000/10,000 Silver	
☐ $3,250/6,500 Gold	☐ $6,700/13,400 Bronze	☐ $7,100/14,200 Bronze	
☐ $6,000/12,000 Silver		☐ Other _____	

If choosing a dental plan, please indicate the contract type: ☐ Individual ☐ Family ☐ None
Requested dental effective date (mm/dd/yyyy): ____ / ____ / _____

Dental coverage applied for:

☐ Dental Direct Basic	☐ Dental Direct Plus
☐ Dental Direct Standard	☐ Dental Direct Elite

These are Qualified Dental Plans, which are certified as providing the pediatric dental essential health benefit.

☐ **I have a Qualified Dental Plan**
By checking this box, you are attesting that you are either purchasing a Qualified Dental Plan from BCBSRI or you have purchased a Qualified Dental Plan certified by HealthSource RI. **Based on this attestation, your medical plan will not include pediatric dental essential health benefits and your premium will be slightly lower.**

Section 3 Spouse or Domestic Partner Information (complete if adding a spouse or domestic partner)

First name _____ M.I. _____ Last name _____ Suffix _____

Coverage applied for: ☐ Medical ☐ Dental Social Security number[1] _____

Home address (if different from applicant) _____ State _____ ZIP code _____

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

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 for medical coverage**):

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 page 6.

Section 4 Dependent Information

(If necessary, please attach dependent addendum found at bcbsri.com/individual/member/forms.)

Dependent #1

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] _____

Email address _____

Primary care provider (PCP) (**Required for medical coverage**):

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 #2

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] _____

Email address _____

Primary care provider (PCP) (**Required for medical coverage**):

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 #3

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] _____

Email address _____

Primary care provider (PCP) (**Required for medical coverage**):

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

☐ Check here if Dependent Addendum form will be attached.

[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

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Section 5 Eligibility

BCBSRI is able to offer health insurance to individuals and families within the guidelines of federal and state regulations. Please complete the information below to check if we are able to offer you insurance. If you are currently enrolled in Medicare, then you are not eligible for BCBSRI medical insurance.

Please answer the following questions so that we may determine your eligibility:

1. Are you a Rhode Island resident? ☐ Yes ☐ No
2. Will your employer (or anyone acting on behalf of your employer) pay or reimburse you (through wage adjustments or otherwise) for any portion of the premium under this policy? ☐ Yes ☐ No ☐ Not applicable
3. Did your employer offer this policy to you as a benefit or otherwise market this policy to you or other individual employees? ☐ Yes ☐ No ☐ Not applicable
4. Do you, your employer (if applicable), or any individual to be insured under this policy intend to treat this policy as a tax exempt benefit under Section 162, 125, or 106 of the Internal Revenue Code? ☐ Yes ☐ No
5. If you answered yes to Question 2, 3, or 4, will your employer's contribution be made through a qualified small employer health reimbursement arrangement (QSEHRA) or individual coverage health reimbursement arrangement (ICHRA)? ☐ Yes ☐ No ☐ Not applicable

Please select the reason you are applying for insurance
In order to be eligible outside of open enrollment, you must apply within 60 days of the event.

☐ Open enrollment
☐ Loss of minimum essential coverage, except when due to non-payment
☐ Marriage, birth, or adoption
☐ Pregnancy
☐ Permanent move to Rhode Island
☐ New citizen or no longer incarcerated
☐ 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 Chapter 11 bankruptcy; or the child turning 26
☐ Enrollment error, misrepresentation, misconduct, or inaction of an Exchange, or non-Exchange entity providing enrollment assistance
☐ Material contract violation by another plan
☐ 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
☐ Change of eligibility for coverage or payment assistance under Medicaid or CHiP (RIteCare)
☐ 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 _____

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

Please remember to sign this application on page 6.

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Section 6 Other Insurance and Medicare Notice

What was the name of your prior **medical** insurance carrier? _____
When did your medical coverage end? (mm/dd/yyyy) _____/_____/_____

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in all health insurance policies you already have. You can compare your current policy and the one you have selected by going on our website or by calling our Individual Sales Department.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department, insurance division, or the State Senior Insurance Counseling Program.

Section 7 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 must be 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.*

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Section 8 HealthSource RI Notice

If you purchase medical insurance directly from Blue Cross & Blue Shield of Rhode Island, you will not be able to get federal premium credits, including the Advance Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR) subsidy. You may be eligible for these tax credits if you purchase your health coverage directly from HealthSource RI. To find out if you are eligible, please contact HealthSource RI at 1-855-651-7873 or visit **www.healthsourceri.com**.

Section 9 Signature

By signing this application, I certify and agree that:

1.) I have read the above statements, or that they have been read to me; and

2.) All responses on this application are the truth, as best I know. If anyone knowingly lied or hid the truth BCBSRI will have the right to:

- Reduce or deny a claim; and
- Cancel the plan, back to the effective date; and
- Recoup any monies paid, back to the effective date.

3.) The applicant is the responsible person for the payment of premiums.

4.) No benefits will apply until the coverage is made effective by BCBSRI.

5.) 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.

☐ By checking this box, you are consenting for Blue Cross & Blue Shield of Rhode Island to contact you via automatic telephone dialing system, by artificial or prerecorded message, or by text message at the phone number you have provided above. You agree that you give your consent to receive health and benefits updates, product offers, and personalized reminders about your health, from Blue Cross & Blue Shield of Rhode Island and its agents that provide mobile communication services. Standard message and data rates may apply. This is an optional service and is not required to enroll in your health plan or purchase goods and services from Blue Cross & Blue Shield of Rhode Island.

SIGN HERE ☞

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

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURE

Section 10 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

For questions, call the Individual Sales Department: 1-855-690-2583 (my0blue) or (401) 459-5550

INTERNAL USE ONLY

Sales eff. date _____ ID# _____ Eligibility _____ Initial _____

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.