Blue Cross Blue Shield of Rhode Island

Dependent Addendum
Plans for Individuals and Families

Please complete the following when you have additional dependents and attach it to the Application.
This Dependent Addendum shall be deemed a part of the Medical and Dental Plan Application for Individuals and Families ("the Application").

Applicant's name _____ Social Security number _____

Phone number _____ Effective date _____

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

Addendum to Section 4 Dependent Information

Dependent #4

First name _____ M.I. _____ Last name _____

Sex assigned at birth ☐ Male ☐ Female Coverage applied for: ☐ Medical ☐ Dental

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

E-mail address _____

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

First name _____ Last name _____

National Provider ID (NPI) # _____ PCP Address _____

City/town _____ State _____ ZIP code _____

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

Dependent #5

First name _____ M.I. _____ Last name _____

Sex assigned at birth ☐ Male ☐ Female Coverage applied for: ☐ Medical ☐ Dental

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

E-mail 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

[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

continued ➤

Dependent #6

First name _____ M.I. _____ Last name _____

Sex assigned at birth ☐ Male ☐ Female Coverage applied for: ☐ Medical ☐ Dental

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

E-mail 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 #7

First name _____ M.I. _____ Last name _____

Sex assigned at birth ☐ Male ☐ Female Coverage applied for: ☐ Medical ☐ Dental

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

E-mail 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

INTERNAL USE ONLY

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

[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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