Blue Cross Blue Shield of Rhode Island

Plans for Individuals and Families
Medical and Dental Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A MEDICAL AND/OR DENTAL PLAN CHANGE. MAKE A PLAN CHANGE ONLINE BY VISITING bcbsri.com/individual/shop.

Please be sure to complete ALL information below, including signing the application, to avoid delays in processing.
(This form can only be used for making a medical or dental plan change.)
Please print clearly using blue or black ink or type in information.

Section 1 Member 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 _____

Email address _____

What kind of a plan change are you making:

- ☐ Medical only (complete section 2)
- ☐ Dental only (complete section 3)
- ☐ Medical and dental (complete sections 2 and 3)

[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.

continued ➤

Section 2 Medical Plan Options

I understand the options available and I hereby request the following coverage changes for myself and my dependents (if applicable):

Choose a medical plan option (please check one):

Choose a **medical** plan type: ☐ Individual ☐ Family

Requested medical effective date (mm/dd/yyyy): ____ / ____ / _____

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 _____	

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

Name	Date of birth (mm/dd/yyyy)	Primary care provider name, address, city/town, state	National Provider ID (NPI)# (Find your PCP's NPI in their profile in the Find Care/Find a Doctor tool on bcbsri.com.)
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		

Section 3 Dental Plan Options

Dental coverage applied for: (*please check one*)

Requested dental effective date (mm/dd/yyyy): ____ / ____ / _____

☐ 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.

Please remember to sign this application on the next page.

continued ➤

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.

Please note, when switching plans:

- If you have satisfied your waiting period on your current plan, the waiting period will not apply to your new plan. If you are switching plans and still in your waiting period, the waiting period will carry over and continue on your new plan.
- This will be your only opportunity to switch plans for Dental Direct coverage. Once you switch, you will not be able to change plans until the next open enrollment period, or during a special enrollment period.

Section 5 Terms, Conditions, and Signatures

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.
- This medical and/or dental plan change 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, and I agree that the electronic signature appearing on this application is the same as a handwritten signature for the purposes of validity, enforceability, and admission.

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

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURE

Please submit your Plan Option Change Form by using one of the methods below:

- Fax to: (401) 459-2385
- Mail to: Blue Cross & Blue Shield of Rhode Island
  Membership Department
  500 Exchange Street
  Providence, Rhode Island 02903-2699

To make a plan change over the phone, contact Customer Service.

Medical	Dental
For questions regarding your **MEDICAL** coverage, call: (401) 429-2289 or 1-866-567-0015 Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m. Saturday and Sunday 8:00 a.m. to noon.	For questions regarding your **DENTAL** coverage, call: (401) 453-4700 or 1-800-831-2400 Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m.



500 Exchange Street • Providence, RI 02903-2699

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