Blue Cross Blue Shield of Rhode Island

Medical and Dental Plan Application for Individuals and Families

Please be sure to complete ALL information below to avoid delays in processing.

Please print clearly using blue or black ink.

Section 1 Applicant Information

Last name ______________________ First name ____________________ M.I. ____ 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) ___ / ___ / _____ Gender ☐ M ☐ F Social security number[1] _____-_____-_______

Current BCBSRI ID (if applicable) ____________________

Home phone number _____-_____-_______

Cell phone number _____-_____-_______

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

What is your primary language spoken? ____________________ Email address______________________

Race (please check one)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino

☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ White

Primary care physician (PCP) (**Required**): First name ____________________ Last name ____________________

PCP Address ____

City/town ______________________________________ State _____ ZIP code ________

Are you a current patient of the PCP listed above? ☐ Yes ☐ No

Are you eligible for Medicare? ☐ Yes ☐ No If yes, what is the effective date?____________

Are you eligible for Medicaid? ☐ Yes ☐ No If yes, what is the effective date?____________

[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 2 Medical and Dental Plan Options

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

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

Medical coverage applied for:

VantageBlue Direct	VantageBlue Direct with Dental	BlueSolutions for HSA Direct	BlueCHiP Direct	BasicBlue Direct
☐ $1,000/2,000 Gold	☐ $1,200/2,400 Gold	☐ $1,400/2,800 Gold	☐ $1,800/3,600 Gold	☐ $2,750/5,500 Gold
☐ $3,050/6,100 Silver		☐ $3,900/7,800 Silver	☐ $4,800/9,600 Silver	☐ $4,900/9,800 Silver
		☐ $6,000/12,000 Bronze		☐ $7,150/14,300 Bronze

Choose a **dental** contract type: ☐ Individual ☐ Family

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

Last name ______________________ First name ______________________ M.I. ____ Suffix ________

Coverage applied for: ☐ Medical ☐ Dental

Home address (if different from applicant) ____

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Gender ☐ M ☐ F Social security number[1] _____-_____-_______

Home phone number ______-______-____________ Cell phone number ______-______-____________

Email address ____

What is your primary language spoken? ____

Primary care physician (PCP) (**Required**): First name ________________ Last name ________________

PCP Address ____

City/town ______________________________ State ______ ZIP code ________

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

Is spouse or domestic partner eligible for Medicare? ☐ Yes ☐ No If yes, what is the effective date?________

Is spouse or domestic partner eligible for Medicaid? ☐ Yes ☐ No If yes, what is the effective date?________

[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 4 Dependent Information

(If necessary, please attach dependent addendum found on BCBSRI.com under the Plans for Individual and Families section.)

Dependent #1

Last name ______________________ First name ______________________ M.I. ____________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number[1] ______-_____-__________

Email address ____

Primary care physician (PCP) (**Required**): First name ________________ Last name ________________

PCP Address ____

City/town ______________________________ State ______ ZIP code ________

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No
Is dependent eligible for Medicare? ☐ Yes ☐ No If yes, what is the effective date?______
Is dependent eligible for Medicaid? ☐ Yes ☐ No If yes, what is the effective date?______

Dependent #2

Last name ______________________ First name ______________________ M.I. ____________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number[1] ______-_____-__________

Email address ____

Primary care physician (PCP) (**Required**): First name ________________ Last name ________________

PCP Address ____

City/town ______________________________ State ______ ZIP code ________

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No
Is dependent eligible for Medicare? ☐ Yes ☐ No If yes, what is the effective date?______
Is dependent eligible for Medicaid? ☐ Yes ☐ No If yes, what is the effective date?______

Dependent #3

Last name ______________________ First name ______________________ M.I. ____________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number[1] ______-_____-__________

Email address ____

Primary care physician (PCP) (**Required**): First name ________________ Last name ________________

PCP Address ____

City/town ______________________________ State ______ ZIP code ________

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No
Is dependent eligible for Medicare? ☐ Yes ☐ No If yes, what is the effective date?______
Is dependent eligible for Medicaid? ☐ Yes ☐ No If yes, what is the effective date?______

☐ 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 eligible for medical insurance through 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

Please select the reasons you are applying for insurance [check all that apply]

☐ Open enrollment
☐ Loss of coverage
☐ Marriage, birth, or adoption
☐ A permanent move to Rhode Island
☐ Loss of eligibility for other coverage due to the death of the policyholder, loss of employment or reduction of hours of the policyholder's employment, divorce from the policyholder, the policyholder becoming entitled to Medicare, a child no longer eligible for other coverage, or the employer providing other coverage is filing for Chapter 11 bankruptcy.
☐ Enrollment or plan error by an employee of HealthSourceRI or the U.S. Department of Health and Human Services
☐ Substantial contract violation by another insurance carrier
☐ Change of eligibility for coverage under Medicaid or CHiP (RIteCare) or payment assistance under Medicaid or CHiP (RIteCare)

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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.

What was the name of your current or prior **dental** insurance carrier? ________________________________

Is your dental coverage still in effect? ☐ Yes ☐ No

If no, what was the date your coverage ended? (mm/dd/yyyy) ____ / ____ / ______

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.

✓ 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 6-month waiting period applies to denture repairs on some plans.
- A 12-month waiting period applies to root canals, periodontal services, oral surgery, crowns and prosthodontics on some plans.

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 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 (855) 683-6759 or visit **www.healthsourceri.com**.

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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.

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

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: Individual Sales Department: 1-855-690-2583 (my0blue) or (401) 459-5550

INTERNAL USE ONLY

Sales rec'd ____________ Sales eff. date ____________ ID# ____________ Eligibility A T Q N O Other ____________

Complete date ____________ Initial ____________

www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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