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 _____

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) name, address (**Required**) _____

_____

Are you a current patient? ☐ 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 ➤

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	☐ $4,500/9,000 Silver	☐ $2,750/5,500 Gold
☐ $3,000/6,000 Silver		☐ $3,900/7,800 Silver		☐ $4,900/9,800 Silver
		☐ $3,700/7,400 Bronze		☐ $6,850/13,700 Bronze
		☐ $5,350/10,700 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 _____ - _____ - _____

E-mail address _____

What is your primary language spoken? _____ Email address _____

Primary care physician (PCP) name, address (**Required**) _____

_____

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

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] _____ - ____ - _____

E-mail address _____

Primary care physician (PCP) name, address (**Required**) _____

_____

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

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] _____ - ____ - _____

E-mail address _____

Primary care physician (PCP) name, address (**Required**) _____

_____

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

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] _____ - ____ - _____

E-mail address _____

Primary care physician (PCP) name, address (**Required**) _____

_____

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

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 or Medicaid 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. If employed, 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
3. If employed, did your employer offer this policy to you as a benefit or otherwise market this policy to you or other individual employees? ☐ Yes ☐ No
4. Do you, your employer, 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. Are you, your spouse, domestic partner, or any of your dependents presently eligible for or enrolled in the following?

	You	Spouse	Dependent
Medicaid	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medicare	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

- ☐ Open Enrollment
- ☐ You've lost other coverage.
- ☐ You've married, had a child, or adopted a child.
- ☐ You've been enrolled or not enrolled for coverage because of an error by an employee of HealthSource RI or the U.S. Department of Health and Human Services.
- ☐ Your contract with another issuer was not followed.
- ☐ You've moved to Rhode Island on a permanent basis.
- ☐ You've lost 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, and the employer providing other coverage filing for Chapter 11 bankruptcy.
- ☐ You've lost eligibility for coverage under Medicaid or CHiP (RIteCare) or gained eligibility for payment assistance under Medicaid or CHiP (RIteCare).

Section 6 Other Insurance and Medicare

What was the name of your prior **medical** insurance carrier? _____

When did your medical coverage end? (mm/dd/yyyy) ____ / ____ / _____
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 simple extractions and 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**.

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.

SIGN HERE ☞

_____

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

Section 10 Contact Information

Please mail this form 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 _____

Blue Cross Blue Shield of Rhode Island

500 Exchange Street • Providence, RI 02903-2699

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