Health and Dental Plan Application
for Individuals and Families

Blue Cross Blue Shield of Rhode Island

Please be sure to complete ALL information below to avoid delays in processing.
Please **print clearly** using blue or black ink or type in information.

Section 1 Applicant Information

Last name	Suffix	First name	M.I.

Home address (street/apartment number)	City/town	State	ZIP code

Mailing address (if different)(street/apartment number, 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 _____-_____-_____	Best time to call ☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7 p.m.

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

E-mail address

What is your primary language spoken?

Communication preference (please check one)
☐ U.S. mail ☐ E-mail ☐ Home phone ☐ Cell phone

Race (please check one)
☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Multiracial ☐ Native Hawaiian and other Pacific Islander ☐ White

Primary care physician (PCP) name, street, city/town, state and ZIP code

Are you a current patient? ☐ Yes ☐ No

What was the name of your prior health insurance carrier?
_____
_____

What was the date of termination? (mm/dd/yyyy)
_____
Please attach a copy of certificate of creditable coverage showing coverage end date. The application will not be processed until all documents are received.

Section 2 Health, Dental and Vision Plan Options (You may select your medical, dental and vision coverage.)

Health coverage applied for:

VantageBlue Direct	VantageBlue SelectRI Direct	BlueSolutions for HSA Direct	BasicBlue Direct[2]
☐ $1,000/2,000	☐ $500/1,000	☐ $1,500/3,000	☐ $6,600/13,200
☐ $3,000/6,000	☐ $3,000/6,000	☐ $2,400/4,800	
☐ $5,800/11,600	☐ $5,800/11,600	☐ $2,600/5,200	
		☐ $5,000/10,000	

Choose a medical contract type: ☐ Individual ☐ Family
Health plan dependents will be removed from your plan on the first day of the month following their 26th birthday.
Requested medical effective date (mm/dd/yyyy): ____ / ____ / _____

[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-Group-Health-Plans/Overview.html

[2] **If you selected BasicBlue Direct -** BasicBlue Direct applicants over the age of 30, as of the requested effective date, must provide proof of hardship exemption. Please call (401) 459-5550, or toll free at 1-855-690-2583 (my0blue) for eligibility information.

continued ➤

Section 2 Health, Dental and Vision Plan Options (cont.)

Dental coverage applied for: ☐ Dental Direct Basic ☐ Dental Direct Essential ☐ Dental Direct Plus

Choose a dental contract type: ☐ Individual ☐ Family

Please note: Dental dependents, listed in Secton 4 of this application, will be removed from your plan on the first day of the month following their 26th birthday and given the option to purchase a separate plan.

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

What is the name of your current or prior dental insurance carrier? _____

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

If no, what was the date of termination _____

I have a qualified dental plan

☐ By checking this box, you are attesting that you are either purchasing a Dental Direct 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	Suffix	First name	M.I.

Coverage applied for: ☐ Medical ☐ Dental

Home address (street/apartment number, city/town, state, ZIP code—if different from applicant)

Date of birth	Gender ☐ M ☐ F	Social Security number[1] ____-_____-_____	What is your primary language spoken?

Home phone number	Cell phone number	Best time to call
_____-_____-_____	_____-_____-_____	☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7 p.m.

E-mail address

Communication preference (please check one)

☐ U.S. mail ☐ E-mail ☐ Home phone ☐ Cell phone

Race (please check one)

☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian and other Pacific Islander ☐ White

Primary care physician (PCP) name, street, city/town, state and 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-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	Social Security number[1] ____-_____-_____	E-mail address	
Primary care physician (PCP) name, street, city/town, state, and ZIP code			
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	Social Security number[1] ____-_____-_____	E-mail address	
Primary care physician (PCP) name, street, city/town, state, and 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-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 health insurance directly or indirectly through an employer-sponsored plan, provided that the plan is of minimum value, you are not eligible for medical insurance. Similarly, if you are eligible for medical insurance through Medicare or Medicaid then you are not eligible for medical insurance.

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

1. 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
2. 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
3. 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
4. Are you self-employed?	☐ Yes	☐ No
5. Have you been in the United States for six months or more?	☐ Yes	☐ No
6. Are you, your spouse, domestic partner, or any of your dependents presently eligible for or enrolled in the following?		
Medical insurance policy	☐ Yes	☐ No
Dental insurance policy	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No
COBRA	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
7. Are you a Rhode Island resident?	☐ Yes	☐ No

Section 6 Medicare and Other Insurance

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 12-month waiting period applies to major restorative and surgical periodontics services for members 19 or older.
- If you are 19 or older and decide to cancel or change your coverage, you must wait 12 months to re-apply. If you re-apply, you must wait an additional 12 months for major restorative and surgical periodontic services.

Section 8 HealthSource RI Notice

If you purchase health 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 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.
- ☐ 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 a Medicaid or CHiP (RIteCare).

Section 10 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; and

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 11 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 _____

500 Exchange Street • Providence, RI 02903-2699

DPAY-15771 • 3179