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.

Applicants name ________________________ Social security number[1] ____-____-________

Phone number ________________________ Effective date ____-____-________

Dependent Information

#4 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, address (**Required**) ____

____

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

#5 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, address (**Required**) ____

____

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

continued ➤

[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

Dependent Information *(continued)*

#6 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, address (**Required**) ____

____

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

#7 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, address (**Required**) ____

____

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

This Dependent Addendum shall be deemed a part of the Medical Plan Application for Individuals and Families ("the Application"); please staple this form to the Application and mail it to the address provided in Section 10 of the Application.

INTERNAL USE ONLY

Sales rec'd __________________ Sales eff. date _________________ ID# ______________________ Eligibility A T Q N O Other ___________________

Complete date __________________ Initial ________________

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