Blue Cross Blue Shield of Rhode Island

Add Dependent Form
Plans for Individuals and Families

Please complete the following when you are adding dependents to your existing BCBSRI policy. Note: If you have different BCBSRI ID numbers for your medical and dental plans - please complete a separate form for each ID number. This Add Dependent form shall be deemed a part of the Medical and Dental Plan Application for Individuals and Families ("the Application").

Applicant's name ______________________ Current BCBSRI ID # ____-____-________

Phone number ____-____-____________ Requested effective date ______________

Section 1 Spouse or Domestic Partner Information (complete if adding a spouse or domestic partner)

Last name ______________ First name ______________ M.I. ______ Suffix ____

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

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 provider (PCP) (**Required**): First name ______________ Last name ______________

National Provider ID (NPI)______________ PCP address ______________________

(Find your PCP's NPI in their profile in the Find a Doctor tool on bcbsri.com)

City/town ______________________ State _____ ZIP code ________

Is spouse/domestic partner 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

continued ➤

Section 2 Dependent Information

Dependent

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 provider (PCP) (**Required**): First name __________________ Last name ________________

NPI#______________ 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

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 provider (PCP) (**Required**): First name __________________ Last name ________________

NPI#______________ 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

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 provider (PCP) (**Required**): First name __________________ Last name ________________

NPI#______________ 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?______

[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 3 Please select the reasons you are adding dependent(s) to your coverage (check all that apply)

☐ Open enrollment

☐ Loss of coverage Event date ______________

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) ____ / ____ / ______

☐ Marriage, birth, or adoption Event date __________

☐ A permanent move to Rhode Island Event date __________

☐ Loss of eligibility for other coverage Event date __________

☐ Change of eligibility for coverage under Medicaid or CHiP (RIteCare) or payment assistance under Medicaid or CHiP (RIteCare) Event date __________

Section 4 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.
- The medical and/or dental plan selected 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.

____

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

Section 5 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

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

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