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.
This Dependent Addendum shall be deemed a part of the Medical and Dental Plan Application for Individuals and Families ("the Application").

Applicants name _____ Social security number ___-___-____

Phone number _____ Effective date ___-___-____

Addendum to Section 4 Dependent Information

Dependent #4

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) (**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 #5

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) (**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?_____

[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 ➤

Dependent #6

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) (**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 #7

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) (**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?_____

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

www.bcbsri.com

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