

Group Plan 65 Member Application for Health Insurance

Please be sure ALL information below is complete to avoid delays in processing.

Please **print clearly** using blue or black ink.

Section 1 Employer Information (To be completed by plan administrator.)			
Group name	Group number	Dept. number	
Section 2 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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)	Current BCBSRI ID number (if applicable)
Home phone number		Cell phone number	
What is your primary language spoken?			
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. Application will not be processed until received.		
If you have Original Medicare, please provide your beneficiary information, Medicare claim number and effective dates below.			
Medicare Claim Number Medicare Hospital Insurance (Part A) Effective Date: Month/Day/Year _____ Medicare Medical Insurance (Part B) Effective Date: Month/Day/Year _____		Health Insurance and Social Security Act Name of beneficiary: Medicare claim number: _____ - _____ - _____ Effective dates: Part A (hospital) ____ / ____ / ____ Part B (medical) ____ / ____ / ____	

Section 3 Eligibility

Are you transferring from an out-of state Blue Cross plan? <input type="checkbox"/> No <input type="checkbox"/> If Yes ►	Name of state	Company name	Subscriber ID
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Are you enrolled in another health insurance plan? No Yes ► If Yes, complete the boxes below.

Name of policy holder with other insurance	Relationship	Policy/contract number
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Name and address of employer who offers this coverage

Name and address of other insurance company

Section 4 Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits, and
- any other purpose directly related to the administration of BCBSRI.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.



Signature of Applicant

Date

Application rec'd date _____ ID # _____



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