# Group Dependent Addendum

Blue Cross Blue Shield of Rhode Island

**Please complete the following when you have more than four dependents and attach it to the Group Member Application.**

| Employer group name | Group number | Dept. number |
|---|---|---|
| Employee name | Social Security number (xxx-xx-xxxx)* | |
| Phone number | Effective date (mm/dd/yyyy) | |

**Dependent Information**

| **Dependent #5** First name | Last name | M.I. | Relationship ☐ Son ☐ Daughter |
|---|---|---|---|
| Date of birth (mm/dd/yyyy) | Social Security number (xxx-xx-xxxx)* | E-mail address | |
| Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans) | | | |
| Are you a current patient? ☐ Yes ☐ No | Provider ID | | |

| **Dependent #6** First name | Last name | M.I. | Relationship ☐ Son ☐ Daughter |
|---|---|---|---|
| Date of birth (mm/dd/yyyy) | Social Security number (xxx-xx-xxxx)* | E-mail address | |
| Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans) | | | |
| Are you a current patient? ☐ Yes ☐ No | Provider ID | | |

| **Dependent #7** First name | Last name | M.I. | Relationship ☐ Son ☐ Daughter |
|---|---|---|---|
| Date of birth (mm/dd/yyyy) | Social Security number (xxx-xx-xxxx)* | E-mail address | |
| Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans) | | | |
| Are you a current patient? ☐ Yes ☐ No | Provider ID | | |

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

| **Dependent #8** First name | Last name | M.I. | Relationship ☐ Son ☐ Daughter |
|---|---|---|---|
| Date of birth (mm/dd/yyyy) | Social Security number (xxx-xx-xxxx)* | E-mail address | |
| Primary care physician (PCP) name, street, city/town, state and ZIP code (**mandatory** for BlueCHiP plans) | | | |
| Are you a current patient? ☐ Yes ☐ No | Provider ID | | |

## 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 and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

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.

SIGN HERE

Signature of applicant Date

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island

www.BCBSRI.com

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