# Large Group Member Application for Health, Dental, and Vision Insurance

Blue Cross Blue Shield of Rhode Island

**Please be sure ALL information below is complete to avoid delays in processing.**
Please **print clearly** using blue or black ink, or type information.

**Section 1** Employer Information (To be completed by plan administrator.)

| Group name | | Effective date (mm/dd/yyyy) | Date of hire (mm/dd/yyyy) |
|---|---|---|---|
| Group number | Dept. number | | |

Choose one:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (Certificate of Creditable Coverage required)
- ☐ Other _____

***or***

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) _____
**(Must add within 30 days of marriage, birth, or adoption of dependent.)**

**Section 2** Employee Information

| Last name | Suffix | First name | M.I. |
|---|---|---|---|
| | | | |

| Home address (street/apartment number) | City/town | State | ZIP code |
|---|---|---|---|
| | | | |

Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)

| Date of birth (mm/dd/yyyy) | Gender ☐ M ☐ F | Social Security number (xxx-xx-xxxx)* | What is your primary spoken language? |
|---|---|---|---|
| | | | |

| Home phone number | Cell phone number |
|---|---|
| | |

Email address

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Civil union ☐ Common law ☐ Domestic partner

Race (please check one)
☐ Prefer not to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Primary care provider (PCP) name, street, city/town, state, and ZIP code (**Required**: You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and your benefits may be reduced.)

| Are you a current patient of the PCP listed above? ☐ 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.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

**Section 3** Health Plan Options

Plan type

☐ Medical: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse, and child(ren)

☐ Dental: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse, and child(ren)

☐ Vision: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse, and child(ren)

What product(s) are you selecting?

☐ BasicBlue
☐ BlueCHiP
☐ BlueSolutions
☐ Blue Choice New England
☐ Classic (if available)
☐ HealthMate Coast-to-Coast
☐ HealthMate Coast-to-Coast Deductible
☐ HealthMate Coast-to-Coast Coinsurance
☐ Network Blue New England
☐ VantageBlue
☐ VantageBlue SelectRI
☐ Blue Cross Dental
☐ Blue Cross Vision
☐ Pharmacy 4-Tier
☐ Pharmacy 5-Tier
☐ Other _____

**Section 4** Spouse or Domestic Partner Information

| Last name | Suffix | First name | M.I. |
|---|---|---|---|
| | | | |

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

| Date of birth (mm/dd/yyyy) | Gender ☐ M ☐ F | Social Security number (xxx-xx-xxxx)* | What is your primary language spoken? |
|---|---|---|---|
| | | | |

| Home phone number | Cell phone number |
|---|---|
| | |

Email address

Race (please check one)

☐ Prefer not to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ White

Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)

| Is this dependent a current patient of the PCP listed above? ☐ 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.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

| **Section 5** Dependent Information (If necessary, please attach dependent addendum.) | | | |
|---|---|---|---|
| **Dependent #1** First name | Last name | M.I. | Relationship<br>☐ Son ☐ Daughter |
| Date of birth<br>(mm/dd/yyyy) | Social Security number<br>(xxx-xx-xxxx)* | Email address | |
| Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**) | | | |
| Is this dependent a current patient of the PCP listed above?<br>☐ Yes ☐ No | Provider ID | | |
| **Dependent #2** First name | Last name | M.I. | Relationship<br>☐ Son ☐ Daughter |
| Date of birth<br>(mm/dd/yyyy) | Social Security number<br>(xxx-xx-xxxx)* | Email address | |
| Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**) | | | |
| Is this dependent a current patient of the PCP listed above?<br>☐ Yes ☐ No | Provider ID | | |
| **Dependent #3** First name | Last name | M.I. | Relationship<br>☐ Son ☐ Daughter |
| Date of birth<br>(mm/dd/yyyy) | Social Security number<br>(xxx-xx-xxxx)* | Email address | |
| Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**) | | | |
| Is this dependent a current patient of the PCP listed above?<br>☐ Yes ☐ No | Provider ID | | |
| **Dependent #4** First name | Last name | M.I. | Relationship<br>☐ Son ☐ Daughter |
| Date of birth<br>(mm/dd/yyyy) | Social Security number<br>(xxx-xx-xxxx)* | Email address | |
| Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**) | | | |
| Is this dependent a current patient of the PCP listed above?<br>☐ Yes ☐ No | Provider ID | | |
| ☐ **Check here if Group Dependent Addendum form will be attached.** | | | |

*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-Group-Health-Plans/Overview.html

## Section 6 Other Insurance

Are you or any of your dependents covered by other insurance?
☐ Yes ☐ No

Name of other insurance company and name(s) of covered person(s):

**Covered person 1** _____
Insurance company _____
Member ID #1 _____

**Covered person 2** _____
Insurance company _____
Member ID #2 _____

What is the name of your prior health insurance carrier?

_____

_____

What was the date of termination? (mm/dd/yyyy)

_____

If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.

Is anyone named in this application eligible for Medicare?
☐ Yes ☐ No

If yes, name of eligible person

_____

Is the eligible person
☐ Over 65 ☐ Disabled

Retired date (if applicable)

_____

Medicare number
☐☐☐☐☐☐☐☐☐☐☐ - ☐☐☐ - ☐☐☐☐☐☐☐ - ☐☐☐☐

Effective dates: (mm/dd/yyyy)
Part A (hospital): _____ Part B (medical): _____

## Section 7 Signature

By signing this form, I certify the information is true and complete to the best of my knowledge.

SIGN HERE

_____
Signature of applicant Date

Application rec'd date_____ ID #_____



Blue Cross Blue Shield of Rhode Island

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