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
☐ 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 ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (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? ☐ Yes ☐ No	Provider ID		
Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (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? ☐ Yes ☐ No	Provider ID		
Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (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? ☐ Yes ☐ No	Provider ID		
Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (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? ☐ 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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