Small Group Member Application
for Medical, 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 in information**.

Section 1 Employer Information (To be completed by employer.)

Group name _____ Effective date___ / ___ / _____ Date of hire ___ / ___ / _____

Group number_____Department number _____

Choose one:

- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (Evidence of prior coverage)
- ☐ Other_____

or **Add dependent(s)**

- ☐ Spouse
- ☐ Dependent

(Must apply within 30 days of marriage, birth, or adoption of dependent.)

Section 2 Employee Information

Last name _____ First name _____ M.I. ____ Suffix _____

Home address _____ City/town _____ State _____ ZIP code _____

Mailing address _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Gender ☐ M ☐ F Social security number* _____-____-_____

Home phone number _____-_____-_____ Cell phone number _____-_____-_____

Marital status (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Common Law ☐ Civil Union ☐ Domestic Partner

What is your primary language spoken? _____E-mail address _____

Race (please check one) ☐ Prefer not to answer

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ White

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

National Provider ID (NPI): _____

*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

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Section 3 Health Plan Options

Plan Type

☐ **Medical:** ☐ Individual ☐ Family

☐ **Dental:** ☐ Individual ☐ Family

☐ **Vision:** ☐ Individual ☐ Family

What product are you selecting

	COINSURANCE	DEDUCTIBLE
☐ **VantageBlue**		
☐ **VantageBlue SelectRI**		
☐ **BasicBlue**		
☐ **BlueSolutions**		
☐ **BlueCHiP Advance**		
☐ **Network Blue New England**		
☐ **Blue Choice New England**		

Section 4 Spouse or Domestic Partner Information

Last name _____ First name _____ M.I. _____ Suffix _____

Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Home address (if different from applicant) _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Gender ☐ M ☐ F Social security number* _____-____-_____

Home phone number _____-_____-_____ Cell phone number _____-_____-_____

E-mail 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

National Provider ID (NPI): _____

Section 5 Dependent Information

Dependent #1

Last name _____ First name _____ M.I. _____Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number* _____-____-_____

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

National Provider ID (NPI): _____

* 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

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Dependent #2

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number* _____ - _____ - _____

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

National Provider ID (NPI): _____

Dependent #3

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number* _____ - _____ - _____

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

National Provider ID (NPI): _____

Dependent #4

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number* _____ - _____ - _____

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

National Provider ID (NPI): _____

Dependent #5

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number* _____ - _____ - _____

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

National Provider ID (NPI): _____

☐ **Check here if Group Dependent Addendum form will be attached.**
(Found on BCBSRI.com in the Small Group Employer Forms Section of Understanding My Plan)

*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

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Section 6 Other Insurance and Medicare

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 medical insurance carrier? _____

When did your medical coverage end? (mm/dd/yyyy) ___ / ___ / _____

Please attach evidence of prior coverage showing coverage and end date.

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: 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 or signature of parent or guardian *if applicant is under 18 years of age* Date

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island

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