Pre-existing Condition Insurance Plan for Rhode Island

Application for Individuals

Blue Cross Blue Shield of Rhode Island

Section 1 Instructions for Completing this Application

To be eligible for coverage, you must be without other health coverage for at least six consecutive months from the date of this application or be transferring from another state's pre-existing condition insurance plan (PCIP).

Here's how you enroll in the Pre-existing Condition Insurance Plan for Rhode Island (PCIPRI).

If you are applying for coverage as a new member:

1. Complete the **PCIPRI Application.** Please write clearly in a blue or black ink.
2. Complete the **Medical Questionnaire.**
3. **Sign both forms** and mail them to the address provided on the application.
   (If the applicant is under age 18, the parent or guardian must sign the application on page 4.)

If you are transferring into the PCIPRI from another state's PCIP, you must apply within six months of the date your previous PCIP coverage ended:

1. Complete **Section 2** and **Section 7** on the **PCIPRI Application.** Please write clearly in blue or black ink.
2. Complete the **Medical Questionnaire.**
3. **Sign both forms.**
   (If the applicant is under age 18, the parent or guardian must sign the application on page 4.)
4. Staple these two forms together along with your PCIP Certificate of Creditable Coverage.
5. Send these three forms to the address provided on the application.

If you have any questions, please call us at (401) 351-BLUE (2583) or 1-800-505-BLUE (outside Rhode Island).

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	Social security number (xxx-xx-xxxx)	Best time to call
	☐ M ☐ F		☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7 p.m.

Home phone number	Cell phone number

E-mail address

Marital status (please check one)	What is your primary language spoken?	Communications preference
☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Domestic Partner		☐ U.S. mail ☐ E-mail ☐ Home phone ☐ Cell phone

Race (please check one)

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

continued ➤

Section 2 Applicant Information (continued)

Primary Care Physician (PCP) name, street, city/town, state, and ZIP code (This is **mandatory** information)

What is the name of your prior health insurance carrier?	What was the date of termination (mm/dd/yyyy)? ___ / ___ /_____ Reason for termination
_____ _____	_____ _____

Section 3 Information About Your Citizenship or Immigration Status

Please check one of the following boxes:

☐ **I am a citizen of the United States.**

To process your application, you must provide a copy of a document that confirms your citizenship, such as a copy of your U.S. passport, a copy of your birth certificate, a copy of your certificate of citizenship, or a copy of your naturalization certificate. We reserve the right to validate your citizenship with the Commissioner of Security or Secretary of Homeland Security, as applicable.

☐ **I am a noncitizen national of the United States.**

You must provide a copy of a document that confirms your status as a noncitizen national, such as a copy of a U.S. passport that shows your national status.

☐ **I am a noncitizen who is lawfully present in the United States.**

You must provide a copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number, for verification of your current immigration status. Below is a list of acceptable documents.

- ☐ I-327 (Reentry Permit)
- ☐ I-551 (Permanent Resident Card)
- ☐ I-571 (Refugee Travel Document)
- ☐ I-766 (Employment Authorization Document)
- ☐ Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport
- ☐ Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport
- ☐ I-94 (Arrival/Departure Record) with Unexpired Foreign Passport
- ☐ Unexpired Foreign Passport for Visa Waiver Program travelers
- ☐ I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport
- ☐ DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport
- ☐ Other Document with an I-94 or Alien Number

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Section 4 Other Insurance Notice

Are you enrolled in one of the following? (You must answer each question.)

YES	NO	
☐	☐	Job-based health plan, including COBRA?
☐	☐	Medicare (Part A and/or Part B)?
☐	☐	Medicaid?
☐	☐	Children's Health Insurance Program (CHIP or RIteCare)?
☐	☐	A state high-risk pool?
☐	☐	TRICARE (military health insurance)?
☐	☐	Health coverage provided by a public health plan established by a state, the U.S. government such as coverage provided to veterans enrolled in VA healthcare, or a foreign country?
☐	☐	FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)?
☐	☐	Health benefit plan provided to Peace Corps workers?
☐	☐	Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition?

Based on Federal Government guidelines, if you have answered yes to any of these questions **you are not eligible** for coverage.

Section 5 Eligibility

Please answer the following questions so that we may determine your eligibility. We may request additional information to validate eligibility.

1.	Will your employer or anyone acting on your behalf pay or reimburse you (through wage adjustments or otherwise) for any portion of the premium under this policy?	☐ Yes ☐ No
2.	Did your employer offer this policy to you as a benefit or otherwise market this policy to you or other individual employees?	☐ Yes ☐ No
3.	Do you, or your employer, intend to treat this policy as a tax exempt benefit under Section 162, 125, or 106 of the Internal Revenue Code?	☐ Yes ☐ No
4.	Are you self-employed?	☐ Yes ☐ No
5.	Do you reside in Rhode Island?	☐ Yes ☐ No

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Section 6 Health Pledge

This plan focuses on prevention, wellness, and proper treatment for chronic conditions. To support these goals and to enroll in this plan, you must agree to complete the following action steps:

1. Choose a primary care physician (PCP):
   - Who participates in either a BCBSRI Patient-centered Medical Home (PCMH) or a Chronic Care Sustainability Initiative (CCSI); or
   - Agree to join the BCBSRI Care Coordination Program (CCP) if your PCP does not participate in a PCMH or CCSI. The CCP includes working with a nurse care coordinator to set personal health goal(s). The goals will be based on what you and the coordinator agree is important to your health.
2. Have an annual physical exam within six months of joining this plan.
3. Get the preventive screenings/exams/immunizations recommended for your age and condition.

Section 7 Signature

By signing this application, I certify and agree:

1. I understand that my coverage will not begin until (a) this completed application and all required documents are received and approved, and (b) I am billed for the first month's premium and my payment is received and processed.
2. I understand that it is my responsibility to inform BCBSRI of any health insurance coverage that I may get in the future.
3. I understand that, if I move out of Rhode Island, I must notify BCBSRI so I can be disenrolled.
4. I understand that if I voluntarily disenroll from this plan or if I am disenrolled involuntarily (for example, for failure to pay my premium on time), **I may not re-apply for enrollment until at least 6 months after my coverage ends.**
5. I agree to meet the pledge requirements listed in Section 6 of this form. If I do not meet them, I understand BCBSRI has the right to disenroll me from this plan.
6. I understand that I am the responsible person for the payment of premiums.
7. I understand that, by signing below, I certify that I have read the above statements, or that they have been read to me, and all information and documents provided as part of this application for coverage are complete, accurate, and true to the best of my knowledge. I understand that, if this application has intentional material misstatements or omissions, the plan may, during the first 2 years of my enrollment, (a) cancel my enrollment as though it were never effective and refund my premiums, less any claims that were paid on my behalf, and/or (b) take any other action available by law.

SIGN HERE ☞

_____

Signature of applicant or signature of parent or guardian if applicant is under 18 years of age. Date

If you are transferring from another PCIP, please list the month, day, and year you would like your new coverage to start: _____(mm/dd/yyyy)

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Section 8	Contact Information
Please mail this form to:	Blue Cross & Blue Shield of Rhode Island Individual Sales Department 500 Exchange Street Providence, RI 02903-2699
For questions, call:	Individual Sales Department (401) 351-BLUE (2583) or 1-800-505-BLUE (2583) (outside of Rhode Island)

Once you've completed the application, you must complete the medical questionnaire.

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INTERNAL USE ONLY

Sales rec'd _____ Sales eff. date _____ ID# _____ Eligibility PCIPRI Transfer _____

MU rec'd _____ Send out _____ Send back in _____ Results _____ Determination _____

Complete date _____ Initial _____ AB Lev 1 Lev 2 Memb. rec'd _____

Blue Cross Blue Shield of Rhode Island

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

Pre-existing Condition Insurance Plan for Rhode Island

Medical Questionnaire

Blue Cross Blue Shield of Rhode Island

You must complete the following questionnaire if you are applying to enroll in the Pre-existing Condition Insurance Plan for Rhode Island (PCIPRI).

Applicant name	Home phone
Mailing address (street, city/town, ZIP code)	Date of birth (mm/dd/yyyy)
Primary care physician (PCP) name, street, city/town, state and ZIP code	

1. Applicant height ___'_____" weight _____ lbs.

2. Do you smoke now or have you ever smoked? ☐ Yes ☐ No

   If yes, at what age did you start smoking? _____

   Are you still smoking? ☐ Yes ☐ No

   If no, when did you quit? _____

3. Have you had medical or surgical advice, treatment, or consultation for any accident, injury, illness, or disease in the past for any of the following? (Include routine physical examinations.)

Yes	No		
☐	☐	A.	Diabetes? Age at onset _____, insulin dosage _____ .
☐	☐	B.	Nephritis, kidney stones, or any disease or disorder of the kidneys, prostate, urinary tract, or albumin or sugar in the urine?
☐	☐	C.	Any disease or disorder of the stomach, intestines, rectum, appendix, liver, pancreas or gallbladder, including ulcers, chronic indigestion, or diarrhea?
☐	☐	D.	Chest pain or pressure, shortness of breath, heart murmur, aneurysm, high blood pressure, irregular heartbeats, or any other disease or disorder of the heart or circulatory system?
☐	☐	E.	Epilepsy (seizures), stroke, paralysis, chronic or severe headaches, cerebrovascular disease, or any other disorder of the brain or nervous system?
☐	☐	F.	Treatment for Sickle Cell Anemia?
☐	☐	G.	Diagnosed with Multiple Sclerosis?
☐	☐	H.	Any type of cancer or other tumor?
☐	☐	I.	Asthma, emphysema, chronic cough, spitting of blood, tuberculosis, allergies, or any other disease or disorder of the lungs or respiratory system?
☐	☐	J.	Any disease or disorder of the blood or lymph system, including anemia, leukemia hemophilia, goiter, or other disease or disorder of the glands or thyroid?
☐	☐	K.	Diagnosed with Cystic Fibrosis?
☐	☐	L.	Alcoholism, drug or substance abuse, or addiction?
☐	☐	M.	Have you experienced sudden weight loss, night sweats, persistent fever, malaise, mouth infections, or lymph node enlargement?

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☐ ☐ N. Have you ever been told that you had, or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or AIDS-related conditions?

☐ ☐ O. Positive blood test for HIV?

☐ ☐ P. Are you currently taking any medications? If yes, please list medications below.

☐ ☐ Q. Any disease or disorder of the back, neck, spine, bones, joints, or muscles, including Lyme Disease, gout, rheumatism, or arthritis? Type _____

☐ ☐ R. Treatment or counseling for mental, nervous, or emotional disorders, including depression, Alzheimer's disease, or dementia?

☐ ☐ S. Any disease or disorder of the skin?

☐ ☐ T. Advised by a healthcare provider that future hospitalization, surgery, or treatment is necessary?

U. Other condition - specify _____

If you answered "yes" to any of the conditions outlined in the Medical Questionnaire for you, please complete the following. Attach an additional sheet of paper if more space is needed.

ADDITIONAL SHEETS ATTACHED? ☐ Yes ☐ No

Question 3 Letter _____	Please indicate if you are still receiving treatment. ☐ Yes ☐ No If no, is your provider monitoring your condition? ☐ Yes ☐ No	Illness or nature of complaint/treatment or medication.
Duration dates		Name and address of treating physician or other healthcare provider.
From: Month/Year	To: Month/Year	

Question 3 Letter _____	Please indicate if you are still receiving treatment. ☐ Yes ☐ No If no, is your provider monitoring your condition? ☐ Yes ☐ No	Illness or nature of complaint/treatment or medication.
Duration dates		Name and address of treating physician or other healthcare provider.
From: Month/Year	To: Month/Year	

continued ➤

Question 3 Letter _____	Please indicate if you are still receiving treatment. ☐ Yes ☐ No If no, is your provider monitoring your condition? ☐ Yes ☐ No	Illness or nature of complaint/treatment or medication.
Duration dates		Name and address of treating physician or other healthcare provider.
From: Month/Year	To: Month/Year	

Question 3 Letter _____	Please indicate if you are still receiving treatment. ☐ Yes ☐ No If no, is your provider monitoring your condition? ☐ Yes ☐ No	Illness or nature of complaint/treatment or medication.
Duration dates		Name and address of treating physician or other healthcare provider.
From: Month/Year	To: Month/Year	

Question 3 Letter _____	Please indicate if you are still receiving treatment. ☐ Yes ☐ No If no, is your provider monitoring your condition? ☐ Yes ☐ No	Illness or nature of complaint/treatment or medication.
Duration dates		
From: Month/Year	To: Month/Year	

Other Remarks: _____

_____

NOTE: If your application is not processed within 90 days, you may be requested to update your medical questionnaire.

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READ CAREFULLY BEFORE SIGNING

By signing this form, I authorize BCBSRI to:

1.) Request any provider to give BCBSRI all health information about me for whom coverage is requested, which may include:
   - Treatment plans,
   - Dates of services,
   - Nature of accident or sickness,
   - Record of surgery, and,
   - Lab test results, including HIV.

2.) Use health information to verify the information relevant to this application.

3.) Use the information in this form to invite me to take part in medical management, case management, and/or disease management programs.

This authorization is valid for 24 months from the date below. By signing this form, I further understand this authorization can be withdrawn at any future time by notifying BCBSRI in writing; the withdrawal will not affect the rights of anyone acting on it prior to notice.

Notice must be sent to:

Blue Cross & Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
Attn: Health Analytics Department

I hereby certify that I have read the above statements, or that they have been read to me, and that they are true and complete. If anyone knowingly lied or hid the truth BCBSRI will have the right to deny claims or void the contract. Also, any benefits previously paid will be subject to collection by BCBSRI.

SIGN HERE ☞

Signature of applicant or signature of parent or guardian if applicant is under 18 years of age _____ Date _____

Please mail this form to: **Blue Cross & Blue Shield of Rhode Island**
Individual Sales Department
500 Exchange Street, Providence, Rhode Island 02903-2699

For questions, call: **Individual Sales Department (401) 351-BLUE (2583) or**
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