Small Group Member Application for Health and Dental 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.

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

Group name		Effective date	Date of hire
Group number	Dept. number		

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

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event _____
(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	Gender ☐ M ☐ F	Social Security number*	What is your primary language spoken?

Home phone number	Cell phone number

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Civil Union ☐ Other _____

Primary care physician (PCP) name, street, city/town, state, and ZIP code

Are you a current patient?
☐ Yes ☐ No

Section 3 Health Plan Options

Plan type
☐ Medical: ☐ Individual ☐ Family
☐ Dental: ☐ Individual ☐ Family

*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

What product(s) are you selecting (Indicate the deductible on the line)

☐ BlueSolutions for HSA (Deductible:_____)

☐ HealthMate Coast-to-Coast 2000/4000

☐ LifeStyleBlue1 (check one) ☐ On Your Own ☐ Family Matters ☐ House to Yourself

☐ LifeStyleBlue2 (check one) ☐ On Your Own ☐ Family Matters ☐ House to Yourself

☐ VantageBlue (Deductible:_____)

☐ VantageBlue SelectRI (Deductible:_____)

☐ Dental

Section 4 Spouse Information

Last name	Suffix	First name	M.I.

Coverage applied for:
☐ Medical ☐ Dental

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

Date of birth	Gender ☐ M ☐ F	Social Security number*	What is your primary language spoken?

Home phone number	Cell phone number

Primary care physician (PCP) name, street, city/town, state and ZIP code

Is this dependent a current patient of the PCP listed above?
☐ Yes ☐ No

Section 5 Dependent Information (If necessary, please attach dependent addendum.)

Dependent #1 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter

Coverage applied for:
☐ Medical ☐ Dental

Date of birth	Social Security number*

Primary care physician (PCP) name, street, city/town, state, and ZIP code

Is this dependent a current patient of the PCP listed above?
☐ Yes ☐ No

*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

Dependent #2 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Coverage applied for: ☐ Medical ☐ Dental			
Date of birth	Social Security number*		
Primary care physician (PCP) name, street, city/town, state, and ZIP code			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No			

Dependent #3 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Coverage applied for: ☐ Medical ☐ Dental			
Date of birth	Social Security number*		
Primary care physician (PCP) name, street, city/town, state and ZIP code			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No			

Dependent #4 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Coverage applied for: ☐ Medical ☐ Dental			
Date of birth	Social Security number*		
Primary care physician (PCP) name, street, city/town, state, and ZIP code			
Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No			

☐ **Check here if Group Dependent Addendum form will be attached.**

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 _____

*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

What is the name of your prior health insurance carrier? _____ _____	What was the date of termination? 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:
Part A (hospital): _____ Part B (medical): _____

Section 7 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

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island

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