

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



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: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> COBRA <input type="checkbox"/> Loss of coverage (HIPAA Certificate of Creditable Coverage required) <input type="checkbox"/> Other _____		<b>or</b> Add dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent  Date of event (mm/dd/yyyy) _____ <b>(Must add within 30 days of marriage, birth, or adoption of dependent.)</b>		
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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?	
Home phone number		Cell phone number		
E-mail address				
Marital status (please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Common law <input type="checkbox"/> Other _____				
What is your primary language spoken? _____				
Race (please check one) <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or <b>other</b> Pacific Islander <input type="checkbox"/> White				
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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?

- ☐ BlueCHiP \_\_\_\_\_ ☐ VantageBlue \_\_\_\_\_  
☐ BlueSolutions for HSA \_\_\_\_\_ ☐ VantageBlue SelectRI \_\_\_\_\_  
☐ Classic (if available) \_\_\_\_\_ ☐ Blue Cross Dental \_\_\_\_\_  
☐ HealthMate Coast-to-Coast \_\_\_\_\_ ☐ Blue Cross Vision \_\_\_\_\_  
☐ HealthMate Coast-to-Coast Deductible ☐ Vantage Blue with Dental \_\_\_\_\_  
☐ HealthMate Coast-to-Coast Coinsurance \_\_\_\_\_ ☐ Healthmate Coast-to-Coast with Dental \_\_\_\_\_  
☐ \_\_\_\_\_ ☐ Pharmacy 4-Tier \_\_\_\_\_  
☐ \_\_\_\_\_ ☐ Pharmacy 5-Tier \_\_\_\_\_  
☐ Other \_\_\_\_\_

**Section 4** Spouse Information

Last name	Suffix	First name	M.I.
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Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
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Home phone number	Cell phone number
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E-mail 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 physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)

Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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<b>Section 5</b> Dependent Information (If necessary, please attach dependent addendum.)			
<b>Dependent #1</b> First name		Last name	M.I. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
<b>Dependent #2</b> First name		Last name	M.I. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
<b>Dependent #3</b> First name		Last name	M.I. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
<b>Dependent #4</b> First name		Last name	M.I. Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
<input type="checkbox"/> <b>Check here if Group Dependent Addendum form will be attached.</b>			

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Section 6 Other Insurance			
Are you or any of your dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other insurance company and name(s) of covered person(s): <b>Covered person 1</b> _____ Insurance company _____ Member ID #1 _____ <b>Covered person 2</b> _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of eligible person _____		
Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	<table style="width: 100%;"> <tr> <td style="width: 33%;">Retired date (if applicable) _____</td> <td style="width: 33%;">Medicare number ____ - ____ - ____ - ____</td> </tr> </table>	Retired date (if applicable) _____	Medicare number ____ - ____ - ____ - ____
Retired date (if applicable) _____	Medicare number ____ - ____ - ____ - ____		
Effective dates: (mm/dd/yyyy) Part A (hospital): _____ Part B (medical): _____			
By signing this form, I certify the information is true and complete to the best of my knowledge.			

<div style="border: 1px solid black; padding: 2px; width: 40px;">           SIGN HERE  </div>	Signature of applicant	Date
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Application rec'd date \_\_\_\_\_ ID # \_\_\_\_\_