Plan 65®
Medicare Supplement

Group Plan 65 Member Application for Health 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	Group number	Dept. number

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 ☐ M ☐ F	Social Security number (xxx-xx-xxxx)	Current BCBSRI ID number (if applicable)

Home phone number	Cell phone number

What is your primary language spoken?

What was the name of your prior health insurance carrier?	What was the date of termination? (mm/dd/yyyy)
_____ _____	_____ Please attach a copy of certificate of creditable coverage showing coverage end date. Application will not be processed until received.

If you have Original Medicare, please provide your beneficiary information, Medicare claim number and effective dates below.

Medicare Claim Number

Medicare Hospital Insurance (Part A)
Effective Date: Month/Day/Year

Medicare Medical Insurance (Part B)
Effective Date: Month/Day/Year

Health Insurance and Social Security Act

Name of beneficiary:

Medicare claim number:

__ __ __ - __ __ - __ __ __ __ __

Effective dates:

Part A (hospital) _____ / _____ / _____

Part B (medical) _____ / _____ / _____

continued ➤

Section 3 Eligibility

Are you transferring from an out-of state Blue Cross plan? ☐ No ☐ If Yes ➤	Name of state	Company name	Subscriber ID
Are you enrolled in another health insurance plan? ☐ No ☐ Yes ➤ If Yes, complete the boxes below.			
Name of policy holder with other insurance		Relationship	Policy/contract number
Name and address of employer who offers this coverage			
Name and address of other insurance company			

Section 4 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. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits, and
- any other purpose directly related to the administration of BCBSRI.

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

www.BCBSRI.com

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