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

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) ____________
(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 (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Email address

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Civil union ☐ Common law ☐ Domestic partner

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 ☐ Multiracial

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

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?

☐ Access Blue New England
☐ BasicBlue
☐ BlueCHiP
☐ BlueSolutions
☐ Blue Choice New England
☐ Classic (if available)
☐ HealthMate Coast-to-Coast
☐ HealthMate Coast-to-Coast Deductible
☐ HealthMate Coast-to-Coast Coinsurance
☐ Network Blue New England
☐ VantageBlue
☐ Blue Cross Dental
☐ Blue Cross Vision
☐ Pharmacy 4-Tier
☐ Pharmacy 5-Tier
☐ Other ______________________

Section 4 Spouse or Domestic Partner Information

Last name	Suffix	First name	M.I.

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

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Email 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 provider (PCP) name, street, city/town, state, and ZIP code (**required**)

Is this dependent a current patient of the PCP listed above? Yes 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

Section 5 Dependent Information (If necessary, please attach dependent addendum.)			
Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email 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	Provider ID		
Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email 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	Provider ID		
Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email 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	Provider ID		
Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email 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	Provider ID		
☐ **Check here if Group Dependent Addendum form will be attached.**			

*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

continued ➤

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 ______________________

What is the name of your prior medical insurance carrier?
____
____

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

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: (mm/dd/yyyy)
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 Date

Application rec'd date__________ ID #__________________

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