Large Group Member Application for Health, Dental and Vision 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 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

E-mail address

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

What is your primary language spoken?_____

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? ☐ 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?

- ☑ BlueCHiP _____
- ☐ BlueSolutions for HSA _____
- ☐ Classic (if available) _____
- ☐ HealthMate Coast-to-Coast_____
- ☐ HealthMate Coast-to-Coast Deductible
- ☐ HealthMate Coast-to-Coast Coinsurance __
- ☐ VantageBlue _____
- ☐ VantageBlue SelectRI _____
- ☐ Blue Cross Dental _____
- ☐ Blue Cross Vision_____
- ☐ Vantage Blue with Dental _____
- ☐ Healthmate Coast-to-Coast with Dental _____
- ☐ Pharmacy 4-Tier_____
- ☐ Pharmacy 5-Tier_____
- ☐ Other_____

Section 4 Spouse 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

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? ☐ 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)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)			
Are you a current patient? ☐ 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)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)			
Are you a current patient? ☐ 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)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)			
Are you a current patient? ☐ 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)*	E-mail address	
Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)			
Are you a current patient? ☐ 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

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 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?
☐ 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): _____

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 #_____