

Group Dependent Addendum



Please complete the following for additional dependants and attach it to the Group Member Application.

Employer group name _____ Group number _____ Dept. number _____
Employee name _____ Social security number _____ - _____ - _____
Phone number _____ - _____ - _____ Effective date _____ - _____ - _____

Dependent Information

Dependent #6

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship Son Daughter Coverage applied for: Medical Dental Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number¹ _____ - _____ - _____

Primary care physician (PCP) name, address _____

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

Dependent #7

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship Son Daughter Coverage applied for: Medical Dental Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number¹ _____ - _____ - _____

Primary care physician (PCP) name, address _____

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

Dependent #8

Last name _____ First name _____ M.I. _____ Suffix _____

Relationship Son Daughter Coverage applied for: Medical Dental Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number¹ _____ - _____ - _____

Primary care physician (PCP) name, address _____

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

¹Social 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

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.



Signature of Applicant or signature of parent or guardian
if applicant is under 18 years of age

Date

Application rec'd date _____ ID # _____

¹Social 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



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