Small Group Member Application

for Medical, 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 in information**.

Section 1 Employer Information (To be completed by employer.)

Group name ______________ Effective date___ / ___ / ______ Date of hire ___ / ___ / ______

Group number______________ Department number ______________

Choose one:

- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (Evidence of prior coverage)
- ☐ Other______________

or **Add dependent(s)**

- ☐ Spouse
- ☐ Dependent

(Must apply within 30 days of marriage, birth, or adoption of dependent.)

Section 2 Employee Information

Last name ______________ First name ______________ M.I. ____ Suffix ________

Home address ______________ City/town ______________ State ______ ZIP code __________

Mailing address ______________

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Gender ☐ M ☐ F Social security number* ______-_____-__________

Home phone number ______-______-__________ Cell phone number ______-______-__________

Marital status (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Common Law ☐ Civil Union ☐ Domestic Partner

What is your primary language spoken? ______________ E-mail address ______________

Race (please check one) ☐ Prefer not to answer

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ White

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

*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 3 Health Plan Options

Plan Type

☐ **Medical:** ☐ Individual ☐ Family

☐ **Dental:** ☐ Individual ☐ Family

☐ **Vision:** ☐ Individual ☐ Family

What product are you selecting	COINSURANCE	DEDUCTIBLE	METALLIC LEVEL (Platinum, Gold, Silver, Bronze)
☐ VantageBlue			
☐ VantageBlue SelectRI			
☐ BasicBlue			
☐ BlueSolutions			
☐ BlueCHiP Advance			
☐ Network Blue New England*			

Section 4 Spouse or Domestic Partner Information

Last name ____________ First name ____________ M.I. ______ Suffix ______

Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Home address (if different from applicant) ____________

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Gender ☐ M ☐ F Social security number* ____ - ____ - ____

Home phone number ____ - ____ - ____ Cell phone number ____ - ____ - ____

E-mail 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

Section 5 Dependent Information

Dependent #1

Last name ____________ First name ____________ M.I. ______ Suffix ______

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number** ____ - ____ - ____

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

*Pending approval from the Rhode Island Department of Health

**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 ➤

Dependent #2

Last name ______________________ First name ________________________ M.I. _____________ Suffix _________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number* _____-____-__________

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

Dependent #3

Last name ________________________ First name ________________________ M.I. _____________ Suffix _________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number* _____-____-__________

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

Dependent #4

Last name ________________________ First name ________________________ M.I. _____________ Suffix _________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number* _____-____-__________

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

Dependent #5

Last name ________________________ First name ________________________ M.I. _____________ Suffix _________

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Social security number* _____-____-__________

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

☐ **Check here if Group Dependent Addendum form will be attached.**
(Found on BCBSRI.com in the Small Group Employer Forms Section of Understanding My Plan)

*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 and Medicare

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) ___ / ___ / ______
Please attach evidence of prior coverage showing coverage and end date.

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: 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.

____

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

Application rec'd date______________ ID #______________

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

06/17 PER-149855 • 8465