Large Group 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 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 ☐ 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 physician (PCP) name, street, city/town, state and ZIP code (**Required for BlueCHIP plans**)

Are you a current patient of this PCP? ☐ 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)

What product(s) areyou selecting?

☐ BlueCHiP Flex (Not available to Dining Employees)

☐ HealthMate Coast-to-Coast

☐ Blue Choice

Section 4 Spouse or Domestic Partner Information

Lastname	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 ☐ Multiracial

Primary care physician (PCP) name, street, city/town, state and ZIP code (**required** for BlueCHiP plans)

Are you a current patient of this PCP? ☐ 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 #_____

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com
500 Exchange Street • Providence, RI 02903-2699
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