

# Large Group Member Application for Health 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: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> COBRA <input type="checkbox"/> Loss of coverage (HIPAA Certificate of Creditable Coverage required) <input type="checkbox"/> Other _____		or Add dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Common law <input type="checkbox"/> Other _____			
What is your primary language spoken? _____			
Race (please check one) <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White			
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>required</b> for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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) are you selecting?

- BlueCHiP  
 HealthMate Coast-to-Coast  
 VantageBlue SelectRI  
 Other \_\_\_\_\_

**Section 4** Spouse Information

<b>Last name</b>		<b>Suffix</b>	<b>First name</b>	<b>M.I.</b>
Home address (street/apartment number, city/town, state, ZIP code—if different from employee)				
<b>Date of birth</b> (mm/dd/yyyy)	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Social Security number</b> (XXX-XX-XXXX)*	What is your primary language spoken?	
Home phone number			Cell phone number	
E-mail address				
Race (please check one)				
<input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White				
<b>Primary care physician (PCP) name, street, city/town, state and zip code (required for BlueCHiP plans)</b>				
<b>Are you a current patient?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Provider ID</b>		

\*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](http://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 Firstname	Lastname	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> 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 ( <b>required</b> for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #2 First name	Lastname	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> 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 ( <b>required</b> for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #3 First name	Lastname	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> 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 ( <b>required</b> for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #4 First name	Lastname	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> 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 ( <b>required</b> for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other insurance company and name(s) of covered person(s):	
	Covered person 1	_____
	Insurance company	_____
	Member ID #1	_____
	Covered person 2	_____
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of eligible person
--	---------------------------------

Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> 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.



**Signature of Applicant**

**Date**

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.