

Large Group Member Application for Health, 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 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 (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 spoken language?
Home phone number		Cell phone number	
Email 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"/> Domestic partner			
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 <input type="checkbox"/> Multiracial			
Primary care provider (PCP) name, street, city/town, state, and ZIP code (Required if electing BlueCHiP Flex or Blue Choice) You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and benefits may be reduced.			
Are you a current patient of the PCP listed above?		Provider ID	
<input type="checkbox"/> Yes <input type="checkbox"/> 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

Section 3 Health Plan Options

Plan type

Medical:
 Enrollee only
 Enrollee and spouse
 Enrollee and child(ren)
 Enrollee, spouse, and child(ren)

What product are you selecting?

BlueCHiP
 Blue Choice New England
 HealthMate Coast-to-Coast

Section 4 Spouse or Domestic Partner Information

Last name	Suffix	First name	M.I.
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Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

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?
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Home phone number	Cell phone number
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Email 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 provider (PCP) name, street, city/town, state, and ZIP code (required if electing BlueCHiP Flex or Blue Choice)

Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID
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Section 5 Dependent Information (If necessary, please attach dependent addendum.)			
Dependent #1 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required if electing BlueCHiP Flex or Blue Choice)			
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
Dependent #2 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required if electing Blue CHiP Flex or Blue Choice)			
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
Dependent #3 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required if electing BlueCHiP Flex or Blue Choice)			
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
Dependent #4 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*	Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required if electing BlueCHiP Flex or Blue Choice)			
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	
<input type="checkbox"/> 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

<p>Are you or any of your dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	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.
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Is anyone named in this application eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of eligible person _____
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Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled	Retired date (if applicable) _____	Medicare number ____ - ____ - ____ - ____
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Effective dates: (mm/dd/yyyy)
 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	Date
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Application rec'd date _____ ID # _____

