

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
Home address (street/apartment number)		City/town	State
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"/> 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 physician (PCP) name, street, city/town, state and ZIP code (Required for BlueCHIP plans)			
Are you a current patient of this PCP? <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

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 Flex (Not available to Dining Employees)
 HealthMate Coast-to-Coast
 Blue Choice

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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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? <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	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 ZIPcode (required 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 ZIPcode (required 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 ZIPcode (required 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 ZIPcode (required for BlueCHIP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
<input type="checkbox"/> Check here if Group Dependent Addendum form will be attached.			

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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.
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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): _____

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 # _____



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