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.

Section 1 Employer	nforma	tion (To	be compl	eted by plan admi	nistrator.)	
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 31 days of marriage, birth, or adoption of dependent.)			
Section 2 Employee	lmonna			First name			M.I.
Last name		Suffix		riist name			IVI.1.
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 Socia			ecurity number xxx)*	What is your primary language spoken?		
Home phone number				Cell phone number			
E-mail address							
Marital status (please check ☐ Single ☐ Married		orced	☐ Civil L	Inion 🗌 Comm	non law [Other _	
Race (please check one) American Indian and A Multiracial Native						☐ Hisp	anic or Latino
**Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP and VantageBlue Select plans)							
Are you a current patient? Provider ID 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

^{**}If you choose the VantageBlue Select plan, you must select a Primary Care Physician (PCP) and other healthcare providers (including hospitals, specialists, labs, and durable medical equipment suppliers) from the VantageBlue Select network in order to get the lowest out-of-pocket healthcare costs (e.g., copayments and coinsurance). Providers in the VantageBlue Select network can be found at www.BCBSRI.com/VBSelectProviders or in the Find A Doctor tool on BCBSRI.com. If you do not seek services from a VantageBlue Select network provider or receive a network referral you will be responsible for the applicable higher out-of-network cost sharing.

Section 3 Health Plan Options						
Plan type						
☐ Medical:☐ Enrollee only☐ Enrollee and spouse☐ Enrollee, spouse and child(ren)						
	☐ Dental: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)					
☐ Vision: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)						
What product(s) are you	ı selecting?					
☐ BlueCHiP		🗆 V	'antageBlue		40.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.	
☐ BlueSolutions for HSA_	M	_ U V	antageBlue Select*	*		
BlueSolutions SelectRI			·	one) 🗌 Gold 🗌		
Classic (if available)				RI		
☐ HealthMate Coast-to-C						
HealthMate Coast-to-C			lue Cross Vision			
HealthMate Coast-to-C						
	-	180				
Section 4 Spouse Inf			First name		M	
Section 4 Spouse Inf Last name	formation Suffix		First name		M.I.	
	Suffix	/town, stat		rent from employee)		
Last name	Suffix	Social S	e, ZIP code—if diffe	What is your prir	nary	
Last name Home address (street/apar	Suffix rtment number, city/		e, ZIP code—if diffe		nary	
Last name Home address (street/apar Date of birth (mm/dd/yyyy)	Suffix rtment number, city/	Social S	e, ZIP code—if diffe ecurity number xxx)*	What is your prir language spoke	nary	
Last name Home address (street/apar Date of birth	Suffix rtment number, city/	Social S	e, ZIP code—if diffe	What is your prir language spoke	nary	
Last name Home address (street/apar Date of birth (mm/dd/yyyy)	Suffix rtment number, city/	Social S	e, ZIP code—if diffe ecurity number xxx)*	What is your prir language spoke	nary	
Last name Home address (street/apar Date of birth (mm/dd/yyyy) Home phone number	Suffix rtment number, city/ Gender M F	Social S (xxx-xx-xx	e, ZIP code—if difference curity number xxx)* Cell phone num Black or African A	What is your prir language spoke ber	nary	
Last name Home address (street/apar Date of birth (mm/dd/yyyy) Home phone number E-mail address Race (please check one) American Indian and A	Suffix rtment number, city/ Gender M F Alaska Native Hawaiian and other	Social S (xxx-xx-xx Asian her Pacifi	e, ZIP code—if difference curity number xxx)* Cell phone num Black or African A	What is your prir language spoke ber American	nary n? anic or Latino r BlueCHiP and	

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Section 5 Dependen	t Inform	ation (If necessar	y, please attach de	pendent	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) nar	me, street, city/tov	vn, state and ZIP o	code (ma Vai	ndatory for BlueCHiP and ntageBlue Select plans)	
Are you a current patient?		Provider ID				
Dependent #2 First name		Last name		M.I.	Relationship Son Daughter	
Date of birth (mm/dd/yyyy)	Social S	ecurity number E-mail addres				
**Primary care physician	me, street, city/tov	wn, state and ZIP o		andatory for BlueCHiP and ntageBlue Select 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 S	security number	E-mail address			
**Primary care physician	(PCP) na	me, street, city/to	wn, state and ZIP		undatory for BlueCHiP and ntageBlue Select 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 S (xxx-xx-x	security number	E-mail address			
**Primary care physician	(PCP) na	me, street, city/to	wn, state and ZIP		andatory for BlueCHiP and ntageBlue Select plans)	
Are you a current patient? Yes No		Provider ID				
☐ Check here if Group I	Depender	nt Addendum for	m will be attached	d.		

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dependents covered by other insurance? Insurance company Member ID #1 Covered person 2 Insurance company Member ID #2	Are you or any of your	Name of other insurance company and name(s) of covered person(s):						
Yes No Member ID #1 Covered person 2 Insurance company Member ID #2	dependents covered by							
Member ID #1 Covered person 2 Insurance company Member ID #2		·						
Insurance company Member ID #2		Member ID #1						
Insurance company Member ID #2		Covered person 2		i				
What is the name of your prior health insurance carrier? What was the date of termination? (mm/dd/yyyy)		·						
What is the name of your prior health insurance carrier? If loss of coverage, please attach a copy of the Certificate of Creditable Coverage. Is anyone named in this application eligible If yes, name of eligible person Greditable Coverage. If yes, name of eligible person Over 65 Disabled Over 65 Disabled Medicare number Over 65 Disabled Part A (hospital): Part B (medical):								
Is anyone named in this application eligible for Medicare? Yes No								
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 Retired date (if applicable) Medicare number Over 65 Disabled Effective dates: (mm/dd/yyyy) Part A (hospital): Part B (medical): Section 7 Signature By signing this form, 1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents permit BCBSRI to use such medical records and reports for purposes of: claims payment, case management, coordination of benefits, any other purpose directly related to the administration of BCBSRI, and inviting me and my enrolled members to take part in medical, disease, or case management programs. This approval shall end two (2) years from the issue date of this plan, unless canceled sooner. 2.) I certify the information is true and complete to the best of my knowledge. IF VantageBlue Select is chosen: I understand and acknowledge that in choosing the VantageBlue Select plan, I have chosen a plan with a specified network of providers and that I have reviewed the list of primary care physicals, shotspitals, obstetrican/dynecologists and pediatricians in the network at www.BCBRI.com/VBSelectProvide Although I may choose to go to providers outside of the network, in order to get the lowest out-of-pocket costs will be the same as if I go to a provider in the VantageBlue Select network. I understand that if I do not a referral to see an out-of-network provider, my out-of-pocket costs will be the same as if I go to a provider in the VantageBlue Select network. I understand that if I do not a referral to see an out-of-network provider, other than for emergency care, my out-of-pocket costs will be higher. Signature of applicant	-	prior health	What was	the date of termination? (mm/dd/yyyy)				
Sanyone named in this application eligible If yes, name of eligible person If yes, name of eligible pe	Insurance carrier?							
If yes, name of eligible person Yes								
Step No Retired date (if applicable) Medicare number Over 65 Disabled Part A (hospital): Part B (medical): P								
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Steeligible person								
Effective dates: (mm/dd/yyyy) Part A (hospital):		B (* 1 1 1 2 (* 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(Application to the bound				
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Signature of applicant Date	SIGN							
k _{mer} .	TIENE							
Application rec'd date ID # of Rhode Is	Application rec'd date	ID#		Blue Cross Blue Shield of Rhode Island				

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500 Exchange Street • Providence, RI 02903-2699