



# Regence

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

## APPLICATION FOR ENROLLMENT (For groups of 51-99 employees)

Requested Effective Date (subject to approval): \_\_\_\_\_

Group #: 

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 Sub Group No. \_\_\_\_\_

PLEASE COMPLETE EACH SECTION OF THIS APPLICATION IN INK.

Type of Enrollment

New Applicant

Adding Dependent(s)

### APPLICANT INFORMATION (EMPLOYEE)

Your Name: (first, middle initial, last)				Social Security No.:	Date of Birth:	Full-Time Hire Date:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address			City, State, Zip Code:		Phone Number:	Probationary Period (in days):	
Name of Employer:			Employer Address:		Employer Phone Number:	Eligibility Date or Effective Date of Coverage:	
Job Title:	Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Number of Hours Worked Per Week:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Height:	Weight:	Official Use Only Policy Number:	Official Use Only Policy Eff. Date

### FAMILY MEMBER INFORMATION

List all family members you wish to enroll. Children must be under 25, never married, and dependent on you for support.

Family Member's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight	Enrollment Type*	Gender
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Male <input type="checkbox"/> Female
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Male <input type="checkbox"/> Female
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Male <input type="checkbox"/> Female
						<input type="checkbox"/> Health <input type="checkbox"/> Dental	<input type="checkbox"/> Male <input type="checkbox"/> Female

\* Applicant cannot select broader enrollment coverage for dependents than for the employee.

### PRIOR AND/OR CURRENT COVERAGE INFORMATION (Please complete for proper crediting of waiting periods and coordination of benefits.)

Is any person listed on this application now covered, or has he or she been covered, by any other health insurance, including Medicare, Medicaid, or other Regence BlueShield of Idaho policy, during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period)?.....  Yes  No

If YES, PLEASE COMPLETE ALL INFORMATION BELOW FOR EACH PERSON LISTED ON THIS APPLICATION.

Applicants Name	Insurance Company	Policy Number	Phone Number	Policy Type (Group or Individual)	Date of Policy		Will Current Policy Continue?
					Start Date (mm/dd/yy)	End Date (mm/dd/yy)	
Employee							<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse							<input type="checkbox"/> Yes <input type="checkbox"/> No
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No

(Please use extra paper if necessary.)

If any person listed on this application is covered by Medicare, please complete the following:

Name	Medicare Beneficiary Number	Reason for Medicare Entitlement (age, disability or ESRD)
	Part A	Part B
Date of Medicare Entitlement	_____	_____
	(mm/dd/yy)	(mm/dd/yy)
<ul style="list-style-type: none"> <li>If you had other coverage with another carrier within 63 days (excluding any employee's probationary period) of the request, please attach a copy of your <b>Certificate of Health Coverage</b>; this will ensure proper credit for any preexisting conditions, if applicable.</li> <li>If your coverage is terminated, please state reason: _____</li> <li>If your current coverage will remain active, please indicate if coverage is for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision</li> </ul>		





**DISABILITY INFORMATION**

Are you or any of your dependents currently disabled?  Yes  No (If YES, complete information below.)

Name of Disabled Person	Date of Disability	Nature of Disability	Physician Name	Physician's Address	Physician's Phone

**ACKNOWLEDGEMENT**

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

**STATEMENT OF UNDERSTANDING**

I hereby agree to all the terms and conditions referred to in the group policy (including renewals and modifications thereof) with Regence BlueShield of Idaho, and I further agree to pay the monthly premium and charges in such amount as may be due and payable to maintain my enrollment and the above coverage there under. Until further notice from me in writing, I hereby authorize my employer to deduct from my earnings such amount as may be due and payable and remit the to Regence BlueShield of Idaho.

By signing this application, I represent that all my answers are complete and accurate and understand that Regence BlueShield of Idaho may terminate or rescind an employer's group coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any applicant that was or would have been material to Regence BlueShield of Idaho's acceptance of risk, extension of coverage, provision of benefits or payment of any claim.

Signature of Employee : \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_

Date: \_\_\_\_\_

