

Application For Enrollment

(Experience-rated or ASC)



Regence

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

Type of Enrollment: New Applicant Adding Dependent(s)
 Change current enrollment because of: Marriage Birth Other
 Date Event Occurred _____ New address Name Change

EMPLOYEE INFORMATION					EMPLOYER INFORMATION			Official Use Only	
Employee Name (Last, First, MI)					Employer			Policy Number	Policy Eff. Date
Mailing address					Mailing address			Length of Probationary Period	Group Number
City State Zip					Phone			Sub-group Number	
Date of Full Time Employment	Eligibility Date or Effective Date of Coverage	Average Number of Hours Worked Per Week	Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Current/Prior Coverage Information/Coordination of Benefits				
<p>List self and dependents to be covered. If you have additional dependents, please use another application.</p>					<p>Please indicate for each person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 12 months prior to the proposed effective date of this coverage. If no health insurance coverage was in effect within the past 12 months, please indicate none. *</p>				
Social Security Number	Self & Dependents' Names (Last, First, MI)	Date of Birth	Gender	Relationship	Insurance Company (policy# & phone#)	Dates of Coverage (Mo. & Yr.) From To		Type of Coverage (Group or Individual)	
Employee				Self					
Spouse									
Child									
Child									
Child									
Child									
Child									
Child									

List reason for termination of current/prior coverage: _____

* A "Certificate of Group Health Plan Coverage" must be attached to accurately credit your waiting periods.

(See acknowledgement and signature requirement on reverse)

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 thereunder. 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 same to Regence BlueShield of Idaho.

ACKNOWLEDGEMENT

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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.

Employee's signature _____ Date _____