



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

Regence BlueShield of Idaho
 1602 21st Avenue
 Lewiston, Idaho 83501
 Mail form to: PO Box 1200
 Portland, OR 97207-1200
 Fax to: 1 (866) 303-5117
For groups of 100+ employees

Application For Enrollment/Change (for self-insured groups)

Please print in black or blue ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.** The five boxes directly below should be completed by the Group Administrator.

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION	
New Enrollment due to: <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire-Date _____	
COBRA Enrollment: <input type="checkbox"/> COBRA (select cancellation reason and enter cancellation date below)	
Change: <input type="checkbox"/> Add employee with/without dependent(s) <input type="checkbox"/> Add dependent(s) only - Employee must already be enrolled	
Change due to: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA Coverage Exhausted <input type="checkbox"/> Loss of Eligibility on another plan <input type="checkbox"/> Court Order <input type="checkbox"/> Add Eligible Domestic Partner	Date of Change Event
Demographic Information Change: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change	
Cancellation: <input type="checkbox"/> Employee and All Dependent(s) <input type="checkbox"/> All Dependent(s) <input type="checkbox"/> Cancel Dependent(s) - List: _____	
Cancellation due to: <input type="checkbox"/> Dependent no longer eligible <input type="checkbox"/> Death <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Military Leave <input type="checkbox"/> Divorce, annulment, or termination of Domestic Partnership <input type="checkbox"/> Reduction of Hours <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Other reason _____	Date of Cancellation Event
Product Selection: MEDICAL: <input type="checkbox"/> Innova <input type="checkbox"/> Engage <input type="checkbox"/> Activate <input type="checkbox"/> Regence HSA Healthplan 2.0 <input type="checkbox"/> Preferred <input type="checkbox"/> No Medical DENTAL: <input type="checkbox"/> Encore <input type="checkbox"/> Radiance <input type="checkbox"/> Expressions <input type="checkbox"/> No Dental	
If your Employer offers multiple medical or dental products with the same name, please provide the following information located at the top of your Benefit Summary.	
Deductible \$ _____ Coinsurance _____ / _____ / _____ % Copay \$ _____	



Application For Enrollment/Change (continued)

SECTION 2 - EMPLOYEE INFORMATION

Last Name		First Name	Middle Initial
Mailing Address		City, State, and ZIP Code	
Physical Address		City, State, and ZIP Code	
Daytime Telephone Number ()	E-mail Address		Primary Language
Date of Birth	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	Original Date of Hire
Full-time Date of Hire	Hours Per Week	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
What type of member card would you like to receive? <input type="checkbox"/> Family Level Card (all members listed on the same card) <input type="checkbox"/> Member Level Card (each member on a separate card)			

SECTION 3 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number for each individual covered	Birthdate Mo/Day/Yr
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /
<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/>	<input type="checkbox"/>			/ /

If you need extra space, please request an additional form from your group administrator.

Is any child listed on this application eligible for other employer sponsored coverage through his/her employer or their spouse? No Yes **If yes, list applicant's name(s):**

SECTION 4 - CHILD CUSTODY INFORMATION

If you and your spouse are divorced or legally separated, please indicate below who has Legal custody of your child(ren):

Name of Child(ren)	Father Mother Joint Other				Date awarded	Is the parent without custody required by court decree to provide coverage for the children?		
	Yes	No	If "Yes" list other coverage provided			Yes	No	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____



Application For Enrollment/Change (continued)

SECTION 5 - CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE.

Applicant's Name	Insurance Carrier, Policy Number and Phone Number	Date of Coverage Month/Day/Year		Will coverage continue? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage		Type of Product	
		From	To		<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
6.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
7.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		

MEDICARE If you or any family members listed on this application have Medicare, is coverage:

Part A Part B Part D Please complete the following information:

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement

If you need extra space, please request an additional form from your group administrator.

SECTION 6 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the self-insured plan maintained by my employer (for which Regence BlueShield of Idaho provides claims administration services, but does not assume financial risk or obligation) and I agree to the terms and conditions of that plan. I agree to abide by the plan's enrollment provisions and certify that all those whom I seek to enroll, including myself, meet the plan's eligibility criteria. I understand that coverage cannot start until after I have served any eligibility waiting period included in the plan.

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. I understand that a waiver form must be completed for those individuals who choose not to enroll at this time. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.



Application For Enrollment/Change (continued)

SECTION 6 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 60 days after the marriage, or within 60 days after the birth, adoption, or placement. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express and duly authorized amendment to the plan, no person may change the terms of the plan. No person may waive the requirement that I answer all questions on this application completely and accurately.

I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way acting as agent for Regence BlueShield of Idaho. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Regence BlueShield of Idaho, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence BlueShield of Idaho 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) 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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand there may not be participating providers in all specialty areas.

I understand that a waiting period for coverage of preexisting conditions may apply. **The preexisting waiting period may not apply to any members under the age of 19.** Contact your Group Administrator for more information. A preexisting condition waiting period may be reduced by any prior creditable health coverage I and/or my dependent(s) may have had, as long as there was not a break in such prior coverage greater than 63 days immediately preceding the application for coverage. I have the right to provide evidence of prior coverage. I can contact Regence BlueShield of Idaho for assistance in obtaining proper evidence of prior coverage. NOTE: A preexisting condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before the enrollment date. Pregnancy and phenylketonuria (PKU) are not considered preexisting conditions. Genetic information will not be considered a preexisting condition in the absence of a diagnosis related to such information. In addition, exclusion periods for preexisting conditions are not imposed on a newborn child or a newly adopted child. The maximum preexisting condition period is 12 months.

I have provided these answers as part of the application procedure for the plan and I certify that all information completed on this form is true, correct, and complete. I understand that the plan will rely on each answer in making coverage and rating determinations. For the protection of all enrollees, fraud or misrepresentation of material fact by me for the purposes of defrauding the plan may result in the plan taking any action allowed by law or contract, including pursuit of criminal charges and penalties.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform the plan in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature  _____ Date _____

