



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.

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"> 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 Certificate of Health Coverage; this will ensure proper credit for any preexisting conditions, if applicable. If your coverage is terminated, please state reason: _____ 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 		



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 AND STATEMENT OF UNDERSTANDING

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Regence BlueShield of Idaho and my employer and I agree to the terms and conditions of that master contract. I agree to abide by the Employer's enrollment provisions and certify that all those who I seek to enroll, including myself, meet the eligibility criteria as agreed to by the Group in the master contract. I understand that coverage cannot start until after I have served an eligibility waiting period agreed to by the employer as recorded on Regence BlueShield of Idaho's records.

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.

If I have waived enrollment for myself or any of my dependents (including my spouse or domestic partner) 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 amendment signed by an officer of Regence BlueShield of Idaho, no person, including, but not limited to any independent producer, agent, or employee of Regence BlueShield of Idaho or of my employer, may change the terms of the master contract, any of its amendments, or this application and no person may waive the requirement that I answer all questions on this application completely and accurately. I understand that this application will become part of the contract between Regence BlueShield of Idaho and my employer.

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 required by Regence BlueShield of Idaho to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield of Idaho will rely on each answer in making coverage and rating determinations. For the protection of all members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BlueShield of Idaho may result in Regence BlueShield of Idaho 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 Regence BlueShield of Idaho in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Signature of Employee : _____ Date: _____

Signature of Spouse: _____ Date: _____

