

**Please be sure ALL information below is complete to avoid delays in processing.**

Please print clearly using blue or black ink.

<b>Section 1 Employer Information (To be completed by plan administrator.)</b>					
Group name		Effective date (mm/dd/yyyy)		Date of hire (mm/dd/yyyy)	
Group number	Dept. number				
<p><b>Choose one:</b> <span style="margin-left: 300px;"><i>or</i></span> <b>Add dependent(s)</b></p> <p> <input type="checkbox"/> Open enrollment                 <input type="checkbox"/> Spouse  <input type="checkbox"/> New hire                 <input type="checkbox"/> Dependent  <input type="checkbox"/> COBRA  <input type="checkbox"/> Loss of coverage (HIPAA Certificate of Creditable Coverage required)  <input type="checkbox"/> Other _____             </p> <p style="margin-left: 350px;">Date of event (mm/dd/yyyy) _____ (Must add within 31 days of marriage, birth, or adoption of dependent.)</p>					
<b>Section 2 Employee Information</b>					
Last name		Suffix	First name		M.I.
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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?	
Home phone number			Cell phone number		
Marital status (please check one)					
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Common law <input type="checkbox"/> Other _____					
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)					
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID			
<b>Section 3 Health Plan Options</b>					
Plan type					
<input type="checkbox"/> <b>Medical:</b> <input type="checkbox"/> Enrollee only <input type="checkbox"/> Enrollee and spouse <input type="checkbox"/> Enrollee and child(ren) <input type="checkbox"/> Enrollee, spouse and child(ren)					
<input type="checkbox"/> <b>Dental:</b> <input type="checkbox"/> Enrollee only <input type="checkbox"/> Enrollee and spouse <input type="checkbox"/> Enrollee and child(ren) <input type="checkbox"/> Enrollee, spouse and child(ren)					

\*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See [www.cms.hhs.gov/MandatoryInsRep/](http://www.cms.hhs.gov/MandatoryInsRep/)

What plan(s) are you selecting?  BlueCHiP for Healthy Options  Dental

**Section 4 Spouse Information**

Last name		Suffix	First name	M.I.
Home address (street/apartment number, city/town, state, ZIP code—if different from employee)				
Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?	
Home phone number			Cell phone number	
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>mandatory</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		

**Section 5 Dependent Information (If necessary, please attach dependent addendum.)**

<b>Dependent #1</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>mandatory</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		
<b>Dependent #2</b> First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>mandatory</b> for BlueCHiP plans)				
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID		

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<b>Dependent #3 First name</b>		<b>Last name</b>		<b>M.I.</b>	<b>Relationship</b> <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)			Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code ( <b>mandatory</b> for BlueCHiP plans)					
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID			
<input type="checkbox"/> <b>Check here if Group Dependent Addendum form will be attached.</b>					
<b>Section 6 Other Insurance</b>					
Are you or any of your dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of other insurance company and name(s) of covered person(s):			
		Covered person 1 _____			
		Insurance company _____			
		Member ID #1 _____			
		Covered person 2 _____			
		Insurance company _____			
		Member ID #2 _____			
What is the name of your prior health insurance carrier? _____ _____			What was the date of termination? (mm/dd/yyyy) _____ If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.		
Is anyone named in this application eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, name of eligible person _____		
Is the eligible person <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled		Retired date (if applicable) _____		Medicare number ____ - ____ - ____ - ____	
Effective dates: (mm/dd/yyyy) Part A (hospital): _____ Part B (medical): _____					

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## 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. I 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. I acknowledge that I have read the following BlueCHiP for Healthy Options Pledge and agree to comply with the wellness requirements as outlined. I understand and agree that my dependents aged 12 and over must also comply with the pledge requirements and that it is my obligation to notify, inform, and educate my dependents of these requirements.

### BlueCHiP for Healthy Options Pledge

This plan focuses on primary care, prevention, and wellness. This plan also emphasizes the importance of proper treatment for the chronically ill. To support these goals, and to obtain the Advantage level of benefits, members must pledge to commit to the goals of the BlueCHiP for Healthy Options plan.

I and my dependents aged 12 and over agree to:

- Participate in a smoking cessation program if currently a smoker, or remain smoke free if a non-smoker.
- Participate in a weight loss or weight management program if I have a high body mass index (BMI), or maintain a healthy weight if my BMI is in the healthy range.
- Participate in disease management or case management if identified by Blue Cross & Blue Shield of Rhode Island as an individual who would benefit from these programs.

I/we understand that to obtain the Advantage level of benefits, I/we must participate in the above mentioned programs.



\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

Application rec'd date \_\_\_\_\_ ID # \_\_\_\_\_



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