



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

Regence BlueShield
1800 Ninth Avenue
PO Box 21267
Seattle, Washington 98111-3267

Application For Enrollment/Change

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.

Table with 5 columns: Health Group Number, Subgroup, Group Name, Requested Effective Date, Class

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

New Enrollment:
Applicant Only
Applicant and Dependent(s)

New Enrollment due to:
New Group
Open Enrollment
New Hire
Rehire-Date
COBRA
Non-COBRA Continuation

Product:
MEDICAL:
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 \$

Change:
Add applicant with/without dependent(s)
Add dependent(s) only - Applicant must already be enrolled

Change due to:
Name Change
Address Change
Birth
Marriage
Adoption
Open Enrollment Changes
COBRA Coverage Exhausted
Loss of Eligibility on another plan
Court Order
Add Eligible Domestic Partner
Date of Change Event (required)

Cancellation:
Employee and All Dependent(s)
All Dependent(s)
Cancel Dependent(s) - list:

Cancellation due to:
Dependent no longer eligible
Death
Medicare Entitlement
Military Leave
Divorce, annulment, or termination of Domestic Partnership
Reduction of Hours
Termination of Employment
Other reason
Date of Cancellation Event (required)

SECTION 2 - EMPLOYEE INFORMATION

Applicant Last Name
First Name
Middle Initial

Mailing Address
City, State, and ZIP Code

Physical Address
City, State, and ZIP Code
Daytime Telephone Number

Social Security Number
Full-time Date of Hire
Hours Per Week
Employer

Date of Birth
Gender:
Marital Status:
Primary Language
E-mail Address

What type of member card would you like to receive?
Family Level Card
Member Level Card

\*Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.



**Application For Enrollment/Change (continued)**

**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.*

**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
_____	<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.

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

**Part A**  **Part B**  **Part D**, and 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

Applicant's Name (Non-Medicare)	Insurance Carrier (Policy Number and Phone Number)	Date of Coverage Month/Day/Year		Will coverage continue?	Type of Coverage	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?
		From	To			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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 and my employer and I agree to the terms and conditions of the certificate issued pursuant to it. 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's records.



Application For Enrollment/Change (continued)

**SECTION 5 - CURRENT/PRIOR COVERAGE INFORMATION (continued)**

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. 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/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/domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage/domestic partnership, or within 60 days after the birth, adoption, or placement if payment of additional premium is required to provide coverage for the dependent child. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express amendment signed by an officer of Regence BlueShield, no person, including, but not limited to any independent producer, agent, or employee of Regence BlueShield 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 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. 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, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence BlueShield 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 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 significant lapse in coverage. I have the right to provide evidence of prior coverage. I can contact Regence BlueShield for assistance in obtaining proper evidence of prior coverage.

I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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 in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature  \_\_\_\_\_ Date \_\_\_\_\_

