

# Application For Enrollment

(For groups of 51-99 employees.)



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)				Phone ( )	Employer			Policy Number	Policy Eff. Date
Mailing address				City	State	Zip	Length of Probationary Period	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			
List self and dependents to be covered. If you have additional dependents, please use another application.					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. *				
Social Security Number	Self & Dependents' Names (Last, First, MI)		Date of Birth M D Y	Gender	Relation-ship	Insurance Company (policy# & phone#)	Dates of Coverage (Mo. & Yr.) From To		Type of Coverage (Group or Individual)
Employee - -					Self				
Spouse - -									
Child 1 - -									
Child 2 - -									
Child 3 - -									
Child 4 - -									

List reason for termination of current/prior coverage: \_\_\_\_\_

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

## HEALTH STATEMENT

A. Is any person listed on this application currently disabled?  Yes  No If yes, please explain below.

Name of disabled family member \_\_\_\_\_ Medical condition causing disability \_\_\_\_\_

Physician's name \_\_\_\_\_

**HEALTH STATEMENT, CONT.**

Enter the applicable numbers in the boxes corresponding to each family member regarding their medical conditions within the past two (2) years. For example, if the Employee has sleep apnea, lupus and TMJ, enter 8, 10 and 11 in the first box under Employee.

	Employee	Spouse	Child 1	Child 2	Child 3	Child 4	Office Use Only
B. 1. Current endometriosis 2. Unoperated cataracts 3. Kidney stones within the past 2 years 4. Current conditions resulting from low birth weight 5. Mental/nervous disorders treated within the past 2 years 6. Unoperated gall bladder condition							
7. Emphysema or COPD 8. Sleep apnea 9. Multiple sclerosis 10. TMJ 11. Lupus 12. Angina							
C. 1. Chronic heart or circulatory disease 2. Colostomy conditions 3. Congenital heart conditions							
D. 1. Organ transplants (except cornea) 2. Unrepaired aneurysm 3. Heart attack 4. AIDS or HIV positive							
5. Kidney failure 6. Acute heart failure 7. Stroke							
E. Current pregnancy: <ul style="list-style-type: none"> <li>1. Single Fetus</li> <li>2. Multiple Fetuses</li> </ul>							

**ACKNOWLEDGEMENT**

I acknowledge and understand my health plan 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) 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.

**STATEMENT OF UNDERSTANDING**

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.

By signing this application, I represent that all my answers are complete and accurate and understand that Regence BlueShield of Idaho may terminate or rescind an employer's group coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any applicant that was or would have been material to Regence BlueShield of Idaho's acceptance of risk, extension of coverage, provision of benefits or payment of any claim.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_