



Large Group Health/Dental Enrollment Application With Health Statement

Requested Effective Date (subject to BCI approval) _____

Group Number _____

- | | |
|---|--|
| <input type="checkbox"/> PPO Medical | <input type="checkbox"/> PPO/HSA Blue SM PPO |
| <input type="checkbox"/> Traditional Medical | <input type="checkbox"/> Traditional/HSA Blue SM PPO |
| <input type="checkbox"/> Managed Care Medical | <input type="checkbox"/> Managed Care/HSA Blue SM POS |
| <input type="checkbox"/> PPO Dental | <input type="checkbox"/> Traditional Dental |

Please complete each section of this application in ink.

Applicant Information (Employee)										
Your Name (first, initial, last)				Blue Cross ID No. (if currently enrolled)		Social Security No. / /		Date of Birth / /		<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address				City, State, Zip Code				Phone Number ()		
Full-time Hire Date / /		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Name of Employer			Job Title		Height	Weight
For Managed Care Plans Only			Name of Primary Care Physician (PCP)			Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Use Only PCP		

Family Member Information									
List your spouse and any other eligible family members you wish to enroll. (Please check with your employer to make sure the family members you list meet your employer's eligibility requirements.)							For Managed Care Plans Only		
Family Member's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight		Name of Primary Care Physician (PCP) <small>(For the highest benefit level you must select a PCP)</small>	Existing Patient of PCP?	Office Use Only PCP
	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	

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 Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period)? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If YES , please complete all information below for each person listed on this application.									
Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Health or Dental)	Date of Policy Start Date (mm/dd/yy)	Date of Policy End Date (mm/dd/yy)	Will Current Policy Continue?			
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	

- If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this 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: _____ Termination Date: _____ mm / dd / yy
- If your current coverage will remain active, please indicate if coverage is for: Medical Dental Vision

Type of Enrollment	Change Request
Health Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children	Dental Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children
Change current enrollment because of the following event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____ Date event occurred _____ mm / dd / yy	

Are you or any of your dependents currently disabled? YES NO (If YES, complete information below.)

Nature of Disability _____

Name of Disabled Person _____ Physician's Name _____ Physician's Phone Number _____

Date of Disability _____ Physician's Address _____

Please read the reverse side and sign and date this application.

OVER →

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

Health Statement (Complete this health statement if you apply for coverage for yourself or a family member after the original eligibility period.)

1. Have you or any family member listed on this application ever been advised to have any surgical operation(s) that you or any family member have not yet had?
 YES NO
2. Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted?
 YES NO
3. During the past 90 days, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication?
 YES NO
4. Are you, or any family member, whether or not listed on this application, now pregnant?
 YES NO If pregnant, what is the anticipated delivery date? _____
5. Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage or been offered a program with a rider attached that restricted or excluded benefits for certain conditions?
 YES NO
6. Have you or any family member listed on this application been hospitalized during the last month?
 YES NO
7. Have you or any family member listed on this application ever had, been told he or she had, been counseled or treated for any of the following: alcohol/drug use or abuse, cancer, heart problem/disorder, diabetes, digestive disorder, immune disorder, renal/kidney disease, strokes, mental or nervous disorders or respiratory disorders?
 YES NO

If you checked YES to any question above, please provide details below (please use extra paper if necessary):

Item No.	Person Affected	Mo. / Year	Name of Disease, Symptom or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician

Statement of Understanding

By signing this application, I represent all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
 - The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
 - On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
 - If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
 - I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcidaho.com.
 - Preexisting condition waiting period: There are no benefits available under this contract for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.
- A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.
 - If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
 - My employer's master group contract is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
 - I agree that a facsimile or photocopy of my signature will serve the same as an original.
 - I understand that this application will become part of the contract between the insurer and my employer.
 - **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X _____
 Applicant's Signature

 Date

This application must be signed and dated.