



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

Regence BlueShield
1800 Ninth Avenue
Seattle, WA 98101
Mail form to: PO Box 1200
Portland, OR 97207-1200
Fax to: 1 (866) 303-5117

Application For Enrollment/Change (for self-insured groups)

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, Class, Group Name, Requested Effective Date. Below are fields for Employee Last Name, First Name, and Middle Initial.

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:
[] New Group [] Open Enrollment [] New Hire [] Rehire-Date _____

CHANGE

Change:
[] Add employee with/without dependent(s) [] Add dependent(s) only - Employee must already be enrolled

Change due to:
[] Birth [] Marriage [] Adoption [] Open Enrollment [] COBRA Coverage Exhausted
[] Loss of Eligibility on another plan [] Court Order [] Add Eligible Domestic Partner
Date of Change Event

Demographic Information Change:
[] Name Change [] Address Change

CANCELLATION AND/OR COBRA OR NON-COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)
[] Cancel Employee and All Dependent(s) [] Cancel All Dependent(s)
[] Cancel Dependent(s) - List: _____

COBRA or Non-COBRA Continuation Enrollment:
[] COBRA [] Non-COBRA Continuation

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event:
[] Dependent no longer eligible [] Death [] Medicare Entitlement [] Military Leave
[] Divorce, annulment, or termination of Domestic Partnership [] Reduction of Hours
[] Termination of Employment [] Other Medical Coverage [] Other reason _____
Date of Cancellation Event

SECTION 2 - PLAN SELECTION

MEDICAL: [] Innova [] Engage [] Regence HSA Healthplan 2.0 [] Preferred [] No Medical
If your Employer offers multiple medical products with the same name, please provide the following information located at the top of your Benefit Summary.
Deductible \$ _____ Coinsurance _____ / _____ / _____ % Copay \$ _____

DENTAL: [] Encore [] Expressions [] No Dental



Application For Enrollment/Change (continued)

SECTION 3 - EMPLOYEE INFORMATION

Last Name		First Name	Middle Initial
Mailing Address		City, State, and ZIP Code	
Physical Address		City, State, and ZIP Code	
Daytime Telephone Number ()	E-mail Address		Primary Language
Date of Birth	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	Original Date of Hire
Full-time Date of Hire	Hours Per Week	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married or Registered Domestic Partner <input type="checkbox"/> Non-Registered Domestic Partner*	
What type of member card would you like to receive? <input type="checkbox"/> Family Level Card (all members listed on the same card) <input type="checkbox"/> Member Level Card (each member on a separate card)			

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

SECTION 4 - 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.

Is any child listed on this application eligible for other employer sponsored coverage through his/her employer or their spouse? No Yes If yes, list applicant's name(s):

SECTION 5 - 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
	<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 6 - 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.

Applicant's Name	Insurance Carrier, Policy Number and Phone Number	Date of Coverage Month/Day/Year		Will coverage continue? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Type of Product <input type="checkbox"/> Medical <input type="checkbox"/> Dental
		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
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
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
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
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
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
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

MEDICARE: If you or any family members listed on this application have Medicare, please complete the following information:

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement <input type="checkbox"/> ESRD			
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement <input type="checkbox"/> ESRD			

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

SECTION 7 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the self-insured plan maintained by my employer (for which Regence BlueShield provides claims administration services, but does not assume financial risk or obligation) and I agree to the terms and conditions of that plan. I agree to abide by the plan's enrollment provisions and certify that all those whom I seek to enroll, including myself, meet the plan's eligibility criteria. I understand that coverage cannot start until after I have served any eligibility waiting period included in the plan.

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.



Application For Enrollment/Change (continued)

SECTION 7 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my spouse) 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 and duly authorized amendment to the plan, no person may change the terms of the plan. No person may waive the requirement that I answer all questions on this application completely and accurately.

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 for the plan and I certify that all information completed on this form is true, correct, and complete. I understand that the plan 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 the plan in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature  _____ Date _____

