

Requested Effective Date (subject to Blue Cross of Idaho approval) _____

Group Number _____

- PPO Medical
- Managed Care Medical POS
- PPO Dental
- HSA BlueSM PPO
- HSA BlueSM POS
- Traditional Dental
- Dental Blue Connect
- Vision

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	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Full-time Hire Date	Name of Employer	Job Title	Email Address	
Dependent Information (If you choose not to enroll all your eligible family members, you must complete a waiver form.)					
List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).					
	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Male/Female	Type of Enrollment
Applicant/Employee		SELF		<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)
Dependent's Name (first, initial, last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)
Dependent's Name (first, initial, last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)
Dependent's Name (first, initial, last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)
Dependent's Name (first, initial, last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)
Dependent's Name (first, initial, last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)			Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Use (PCP)

Type of Enrollment	Change Request			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> Health Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents </td> <td style="width: 33%; vertical-align: top;"> Dental Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents </td> <td style="width: 33%; vertical-align: top;"> Vision Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents </td> </tr> </table>	Health Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents	Dental Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents	Vision Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents	Please indicate reason for change in current enrollment below: <input type="checkbox"/> Involuntary loss of group coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court order (copy of court order required) Other _____ Date event occurred _____ mm dd yy
Health Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents	Dental Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents	Vision Coverage (check one) <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self and two or more dependents		

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

OVER

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			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 12 months, 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 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?
 Yes No
6. Have you or any family member listed on this application been hospitalized during the last 5 years?
 Yes No
7. Within the past two years, have you or any member of your family been treated for back/joint disorder?
 Yes No
8. 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

9. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? No Yes If yes, list names below:

Current/Prior Coverage (For Coordination of Benefits, please complete the section below. Use extra paper if necessary).

Do you or any of your family members have other medical and/or dental coverage? Yes No

Coordinating your benefits could reduce the amount you owe a provider. For proper coordination of benefits please complete the section below. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the carrier can determine whose coverage is primary. Use extra paper if necessary.

Other Carrier Information: Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	Type of Coverage	Will <u>this</u> coverage continue?
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No

Disability Information

Are you or any of your dependents currently disabled? YES NO

Nature of Disability

Name of Disabled Person

Physician's Name

Physician's Phone Number

Date of Disability

Physician's Address

Statement of Understanding

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

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- Blue Cross of Idaho may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- 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 **bcidaho.com**.

- My employer's master group policy 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 policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Blue Cross of Idaho.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- **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