Blue Cross of Idaho®

Statewide School Retiree Application

Requested Effective Date _____

❑ **Retiree Deferral Request**

SCHOOL DISTRICT INSTRUCTIONS: Please have the Retiree complete and sign this form, then complete your portion on the back. Have your participating school district or school related group official sign and return the form to Blue Cross of Idaho.

RETIREE INSTRUCTIONS: Please complete the information below and sign and date the back of the form.

Applicant Information *(Retiree)*

First Name	Last Name	Middle Initial	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Address	City, State, Zip Code	Phone Number	
Social Security Number	Blue Cross of Idaho Identification Number	Blue Cross of Idaho Group Number	
Medicare Beneficiary Number	Date of Retirement	Birthdate	

Dependent Information – Please include the following eligible dependents who are currently covered under my program and will continue to be covered under my Retiree Program. 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).*

Dependent Spouse's Name	Spouse's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate

Medical Coverage – Please choose appropriate coverage from the selections below.
Retiree enrollment may be equal to or lesser than active employee enrollment.

UNDER 65

	Health	Dental (if applicable)	Vision (if applicable)
Employee	❑ PPO ❑ HSA ❑ POS	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑
Spouse	❑ PPO ❑ HSA ❑ POS	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑
Child	❑ PPO ❑ HSA ❑ POS	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑
Child	❑ PPO ❑ HSA ❑ POS	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑

OVER 65

	Retiree Plan with RX	Retiree Plan without RX	Dental Coverage (if applicable)	Vision (if applicable)	Medicare Supplement*	Medicare Advantage**
Employee	❑ Option 1 ❑ Option 2 ❑ Option 3	❑	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑	❑	❑
Spouse	❑ Option 1 ❑ Option 2 ❑ Option 3	❑	❑ Blue Cross of Idaho Dental ❑ Dental Blue Connect	❑	❑	❑

*** A Medicare Supplement enrollment form is required to enroll in Blue Cross of Idaho's Medicare Supplement plans. Call 1-888-GO CROSS (1-888-462-7677) toll free to request a form and plan information.**

****A Medicare Advantage enrollment form is required to enroll in Blue Cross of Idaho's Medicare Advantage plans. Call 1-888-492-2583 toll free to request a form and plan information.**

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • *Mailing Address:* P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

Form No. 4-150 (04-17)

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

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	

Benefits offered to Retirees **under age 65**, under the Blue Cross of Idaho School Insurance Program, are to be the same benefits offered to active employees. If you had dental coverage through BCI while an active employee, you will be allowed to continue that dental coverage as a Retiree, as long as the group offers that benefit to its employees.

Retirees and/or spouses **over the age of 65** will be enrolled in our Blue Cross of Idaho School Insurance Over 65 Medicare Program and **must** be enrolled in Parts A and B. You are eligible for dental benefits if the participating school district or school related group you retired from participates in BCI's school program and you were enrolled in a dental plan through your participating school district or school related group for **12 months prior to enrolling in this retiree program.**

Please note that Blue Cross of Idaho cannot guarantee billing or payment of all policies selected by PERSI. If for any reason your premiums cannot be paid by PERSI, Blue Cross of Idaho will bill you directly.

RETIREE'S signature: _____ Date: _____

I authorize the Public Employee Retirement System of Idaho (PERSI) and Blue Cross of Idaho to exchange my address and enrollment information for the purpose of administering this plan.

RETIREE'S signature: _____ Date: _____

Sign for Deferment Only

I choose to defer my enrollment in the retiree program as well as my draw on unused sick leave entitlement with PERSI. I understand if I choose not to continue coverage at the time of retirement I may not be able to enroll at a later date. Later enrollment is possible only if your school district or school related group remains with Blue Cross of Idaho and you maintain continuous coverage. If your school district chooses another carrier, you will not be able to enroll in the program.

RETIREE'S signature: _____ Date: _____

TO BE COMPLETED BY THE PARTICIPATING SCHOOL DISTRICT OR SCHOOL RELATED GROUP:

Not necessary for currently enrolled retirees

Coverage paid by the Participating School District or School Related Group through the month of: _____, 20_____

_____

Signature of Participating School District or School Related Group Official

_____ _____

Name of Participating School Group or School Related Group *Group Number*