

# Group Plan 65 Member Application for Health Insurance

**Please be sure ALL information below is complete to avoid delays in processing.**  
Please **print clearly** using blue or black ink.

<b>Section 1 Employer Information (To be completed by plan administrator.)</b>				
Group name		Group number		Dept. number
<b>Section 2 Applicant Information</b>				
Last name		Suffix	First name	
			M.I.	
Home address (street/apartment number)		City/town		State
				ZIP code
Mailing address (if different)(street/apartment number, city/town, state, ZIP code)				
Date of birth (mm/dd/yyyy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)	
			Current BCBSRI ID number (if applicable)	
Home phone number			Cell phone number	
What is your primary language spoken?				
What was the name of your prior health insurance carrier?		What was the date of termination? (mm/dd/yyyy)		
Please attach a copy of certificate of creditable coverage showing coverage end date. Application will not be processed until received.				
If you have Original Medicare, please provide your beneficiary information, Medicare claim number and effective dates below.				
<b>Medicare Claim Number</b>		<div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 10px;"><b>Health Insurance and Social Security Act</b></div> <p>Name of beneficiary:</p> <p>Medicare claim number:</p> <p>Effective dates:</p> <p>Part A (hospital) ____ / ____ / ____</p> <p>Part B (medical) ____ / ____ / ____</p>		
<b>Medicare Hospital Insurance (Part A)</b>				
Effective Date: Month/Day/Year				
<b>Medicare Medical Insurance (Part B)</b>				
Effective Date: Month/Day/Year				

**Section 3 Eligibility**

Are you transferring from an out-of state Blue Cross plan?

☐ No ☐ If Yes ➤

Name of state

Company name

Subscriber ID

Are you enrolled in another health insurance plan? ☐ No ☐ Yes ➤ If Yes, complete the boxes below.

Name of policy holder with other insurance

Relationship

Policy/contract number

Name and address of employer who offers this coverage

Name and address of other insurance company

**Section 4 Signature**

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits, and
- any other purpose directly related to the administration of BCBSRI.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

SIGN  
HERE

Signature of Applicant

Date

Application rec'd date \_\_\_\_\_ ID # \_\_\_\_\_



www.BCBSRI.com

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