



Blue Cross
Blue Shield
of Rhode Island

City of Providence Retirees

How to Choose Your Blue Cross Medical Coverage

You have three choices for coverage:

1. BlueCHIP for Medicare Group Plus (HMO)
2. Group Plan 65 medical only and an individual Part D Prescription Drug Plan (PDP) of your choice
3. Group Plan 65 and Group Blue MedicareRx

You only need to fill out the application form(s) for the option you choose.


1. BlueCHIP for Medicare Group Plus (HMO)

Fill out *only* the BlueCHIP for Medicare application.

BlueCHIP For Medicare		BlueCHIP for Medicare 2012 Employer Group Enrollment Request Form																	
Please contact BlueCHIP for Medicare if you need information in another language or format (large print).																			
To Enroll in a BlueCHIP for Medicare Employer Group Plan, Please Provide the Following Information:																			
Employer or Union Name:				Group #:															
Please check which plan you want to enroll in:																			
<input type="checkbox"/> BlueCHIP for Medicare Group Plus (HMO) <input type="checkbox"/> BlueCHIP for Medicare Group Preferred Unlimited (HMO-POS)																			
<input type="checkbox"/> BlueCHIP for Medicare Group Preferred (HMO-POS)																			
LAST Name:		FIRST Name:		Middle Initial: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.															
Birth Date: (MM/DD/YYYY)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Home Phone Number: () - - - - -															
				Alternate Phone Number: () - - - - -															
Permanent Residence Street Address: (P.O. Box is not allowed)																			
City:				State: ZIP Code:															
Mailing Address (only if different from your Permanent Residence Address):																			
Street Address:				City: State: ZIP Code:															
Primary Language Spoken:																			
E-mail Address: (providing this information is optional)																			
Please Provide Your Medicare Insurance Information:																			
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none">• Please fill in these blanks so they match your red, white and blue Medicare card <p>--OR--</p> <ul style="list-style-type: none">• Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>			<table border="1"><thead><tr><th colspan="2">MEDICARE HEALTH INSURANCE</th></tr><tr><th colspan="2">SAMPLE ONLY</th></tr></thead><tbody><tr><td colspan="2">Name:</td></tr><tr><td>Medicare Claim Number:</td><td>Sex</td></tr><tr><td>Is Entitled To</td><td>Effective Date</td></tr><tr><td>HOSPITAL (Part A)</td><td></td></tr><tr><td>MEDICAL (Part B)</td><td></td></tr></tbody></table>			MEDICARE HEALTH INSURANCE		SAMPLE ONLY		Name:		Medicare Claim Number:	Sex	Is Entitled To	Effective Date	HOSPITAL (Part A)		MEDICAL (Part B)	
MEDICARE HEALTH INSURANCE																			
SAMPLE ONLY																			
Name:																			
Medicare Claim Number:	Sex																		
Is Entitled To	Effective Date																		
HOSPITAL (Part A)																			
MEDICAL (Part B)																			
Please Read and Answer These Important Questions:																			
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, retirement date (month/date/year): If no, name of retiree:																			
2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: Name of dependents:																			
3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No																			

Plan 65[®]
Medicare Supplement

**Group Plan 65 Member
Application for Health
Insurance**

 **Blue Cross
Blue Shield**
of Rhode Island

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

Section 1 Employer Information (To be completed by plan administrator)			
Group name	Group number	Dept. number	
Section 2 Applicant Information			
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)	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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.			
Medicare Claim Number Medicare Hospital Insurance (Part A) Effective Date: Month/Day/Year Medicare Medical Insurance (Part B) Effective Date: Month/Day/Year		<div style="text-align: center; border-bottom: 1px solid black; padding-bottom: 5px;"> Health Insurance and Social Security Act </div> Name of beneficiary: Medicare claim number: <div style="border-top: 1px solid black; height: 20px; width: 100%;"></div> Effective dates: Part A (hospital) ____/____/____ Part B (medical) ____/____/____	

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continued ►

City of Providence Retirees

3. Group Plan 65 medical *and* Group Blue MedicareRx

Fill out *both* the Plan 65 application and Blue MedicareRx applications.

Plan65[®]
Medicare Supplement

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.

Section 1 Employer Information (To be completed by plan administrator)			
Group name		Group number	Dept. number

Section 2 Applicant Information			
Last name		Suffix	First name
Home address (street/apartment number)		City/town	State
Mailing address (if different) (street/apartment number, city/town, state, ZIP code)		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.			
Medicare Claim Number		Health Insurance and Social Security Act	
Medicare Hospital Insurance (Part A) Effective Date: Month/Day/Year		Name of beneficiary:	
Medicare Medical Insurance (Part B) Effective Date: Month/Day/Year		Medicare claim number:	
		Effective dates:	
		Part A (hospital) ____/____/____	
		Part B (medical) ____/____/____	

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continued >

Official Use Only: Date Stamp



Blue MedicareRxSM (PDP) Medicare Prescription Drug Plan 2012 Enrollment Form

Turn completed applications to your Employer

Please refer to the Blue MedicareRx (PDP) Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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