

Large Group Member Application for Health, Dental, and Vision Insurance



Please be sure ALL information below is complete to avoid delays in processing.

Please print clearly using blue or black ink, or type information.

Section 1 Employer Information (To be completed by plan administrator.)			
Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number	Dept. number		
Choose one: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> COBRA <input type="checkbox"/> Loss of coverage (HIPAA Certificate of Creditable Coverage required) <input type="checkbox"/> Other _____		or	Add dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Date of event (mm/dd/yyyy) _____ (Must add within 30 days of marriage, birth, or adoption of dependent.)
Section 2 Employee Information			
Last name		Suffix	First name
Home address (street/apartment number)		City/town	State
Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)			
Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
Home phone number		Cell phone number	
Email address			
Marital status (please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil union <input type="checkbox"/> Common law <input type="checkbox"/> Domestic partner			
Race (please check one) <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiracial			
Primary care provider (PCP) name, street, city/town, state, and ZIP code (Required: You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and your benefits may be reduced.)			
Are you a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider ID	

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

Section 3 Health Plan Options

Plan type

Medical: Enrollee only Enrollee and spouse Enrollee and child(ren)
 Enrollee, spouse, and child(ren)

Dental: Enrollee only Enrollee and spouse Enrollee and child(ren)
 Enrollee, spouse, and child(ren)

Vision: Enrollee only Enrollee and spouse Enrollee and child(ren)
 Enrollee, spouse, and child(ren)

What product(s) are you selecting?

Access Blue New England HealthMate Coast-to-Coast Coinsurance
 BasicBlue Network Blue New England
 BlueCHiP VantageBlue
 BlueSolutions Blue Cross Dental
 Blue Choice New England Blue Cross Vision
 Classic (if available) Pharmacy 4-Tier
 HealthMate Coast-to-Coast Pharmacy 5-Tier
 HealthMate Coast-to-Coast Deductible Other _____

Section 4 Spouse or Domestic Partner Information

Last name	Suffix	First name	M.I.
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Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?
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Home phone number	Cell phone number
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Email address

Race (please check one)

Prefer not to answer American Indian or Alaska Native Asian Black or African-American
 Hispanic or Latino Native Hawaiian or other Pacific Islander White

Primary care provider (PCP) name, street, city/town, state, and ZIP code (**required**)

Is this dependent a current patient of the PCP listed above? Yes No	Provider ID
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Section 5 Dependent Information (If necessary, please attach dependent addendum.)				
Dependent #1 First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required)				
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider ID	
Dependent #2 First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required)				
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider ID	
Dependent #3 First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required)				
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider ID	
Dependent #4 First name		Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		Email address	
Primary care provider (PCP) name, street, city/town, state, and ZIP code (required)				
Is this dependent a current patient of the PCP listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider ID	
<input type="checkbox"/> Check here if Group Dependent Addendum form will be attached.				

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

Section 6 Other Insurance

Are you or any of your dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other insurance company and name(s) of covered person(s): Covered person 1 _____ Insurance company _____ Member ID #1 _____ Covered person 2 _____ Insurance company _____ Member ID #2 _____
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What is the name of your prior medical insurance carrier? _____ _____	When did your medical coverage end? (mm/dd/yyyy) _____
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Is anyone named in this application eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of eligible person _____
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Is the eligible person Over 65 Disabled	Retired date (if applicable) _____	Medicare number _____ - _____ - _____
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Effective dates: (mm/dd/yyyy)
 Part A (hospital): _____ Part B (medical): _____

Section 7 Signature

By signing this form, I certify the information is true and complete to the best of my knowledge.

SIGN HERE 	_____ Signature of applicant	_____ Date
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Application rec'd date _____ ID # _____

