



An Independent Licensee of the Blue Cross and Blue Shield Association

Please complete all sections in black ink

EMPLOYEE ENROLLMENT & CHANGE FORM

This Section for Regence BlueShield Use Only – RIQ Code: _____ Rel ICN#: _____
ACRW Loaded: _____ COB Loaded: _____ Date Completed: _____ Auditor Initials: _____

EMPLOYEE SECTION:

Employee Legal Name: _____

Social Security #: _____ Phone #: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Mailing Address, if different: _____

City: _____ State: _____ Zip: _____

Employee Email Address: _____

Marital Status: Married Single Date of Marriage: _____

Has Regence BlueShield assigned an alternate Identification number to you previously?
 Yes No If yes, please provide if available: _____

<p>A Reason Must be Checked for Add, Change, or Cancellation:</p> <p><input type="checkbox"/> Add employee with/without dependent(s) <input type="checkbox"/> Add dependent(s) only</p> <p>Add due to:</p> <p><input type="checkbox"/> New group <input type="checkbox"/> Open enrollment changes <input type="checkbox"/> New employee</p> <p><input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> COBRA coverage exhausted</p> <p><input type="checkbox"/> Loss of eligibility on another coverage</p> <p><input type="checkbox"/> Add DP (domestic partner) and dependent(s) (If employer allows DP coverage) (Must attach DP affidavit)</p> <p><input type="checkbox"/> Add dependent(s) only, of DP (domestic partner) (If employer allows DP coverage) (Must attach DP affidavit)</p> <p><input type="checkbox"/> Name change <input type="checkbox"/> Address change <input type="checkbox"/> Personal Care Provider change</p> <p><input type="checkbox"/> Add to COBRA Effective date: _____ <input type="checkbox"/> Employee and dependent(s) <input type="checkbox"/> Dependent(s) only</p> <p><input type="checkbox"/> Add to 6-month extension Effective date: _____ <input type="checkbox"/> Employee and dependent(s) <input type="checkbox"/> Dependent(s) only</p>	<p>CANCELLATIONS:</p> <p>List names below:</p> <p><input type="checkbox"/> Employee and dependent(s)</p> <p><input type="checkbox"/> Dependent(s) only</p> <p>Intended termination date: _____</p> <p>Select cancel reason:</p> <p><input type="checkbox"/> TE = Termination</p> <p><input type="checkbox"/> RH = Reduction in hours</p> <p><input type="checkbox"/> DC = Dependent child(ren)</p> <p><input type="checkbox"/> DV = Divorced</p> <p><input type="checkbox"/> DE = Death</p> <p><input type="checkbox"/> DX = Disability extension</p> <p><input type="checkbox"/> MI = Medicare ineligible</p> <p><input type="checkbox"/> CE = Voluntary cancellation of COBRA coverage</p>
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Select Plan: PPO Selections Traditional Medical HSA-Qualified PPO Columbia Dental Traditional Dental Other: _____

Medical/Dental (Indicate Selection) M D	Relationship	Name (to appear on ID cards)			Social Security Number or Individual tax payor ID number (ITIN)	Birth Date	Gender M/F	Personal Care Provider for Selections Plan only (First & Last Name)	PCP Rider #	Current Patient Y/N
		Last Name	First Name	M.I.						
<input type="checkbox"/>	<input type="checkbox"/>	Employee								
<input type="checkbox"/>	<input type="checkbox"/>	Spouse								
<input type="checkbox"/>	<input type="checkbox"/>	Child								
<input type="checkbox"/>	<input type="checkbox"/>	Child								
<input type="checkbox"/>	<input type="checkbox"/>	Child								

For children over the age of 19, please give the name(s) and reason(s) for dependency: _____

If any dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:
Name of parent with custody (if parents have dual custody, indicate): _____

If divorced, did the court establish financial responsibility for the child(ren)'s health care? Yes No (Please provide a copy of the divorce decree maintenance agreement outlining coverage specifications.)
If YES, please specify the name and address of the parent with responsibility: _____

Do you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan? Yes No. Will coverage remain in effect? Yes No

IMPORTANT: If you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan, you MUST complete the back of this form.
Completing the information on the back of this form will allow Regence BlueShield to credit any applicable waiting periods for preexisting conditions and process claims quickly and accurately.

EMPLOYEE RELEASE AND AUTHORIZATION: I hereby verify that all of the information specified above is accurate and complete. By signing below, I have authorized the release of information, for myself and my dependents listed above, to Regence BlueShield. (Spouse's signature required if Spouse is electing COBRA.)

EMPLOYEE'S SIGNATURE: _____ DATE: _____ SPOUSE'S SIGNATURE: _____ DATE: _____

EMPLOYER SECTION: *The Employer section must be completed and signed by the Group's Primary Contact Person as listed on the Group Master Application. If not fully completed, this form will be returned unprocessed.*

Group Name: _____ Group Number: _____ Group Phone Number: _____ Group Email Address: _____ Intended Effective Date: _____

Employee Class: _____ Work Location: _____ Date of Hire: _____ Rehire: _____ Date Changed from Part-time to Full-time: _____ Hours Worked Per Week: _____

SIGNATURE OF GROUP'S PRIMARY CONTACT PERSON: _____ **Date:** _____



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Please use black ink

EMPLOYEE SECTION:

If you, the Employee, or any family members who are applying for coverage through Regence BlueShield currently have another health insurance coverage, or have had any other health insurance coverage within the past 6 (six) months before starting this coverage with Regence BlueShield, you should complete this section. Other health insurance coverage includes another plan with Regence BlueShield, any other company, any other Blue Shield or Blue Cross coverage, any retirement plan, Medicare, or Tricare. The information will be used to establish eligibility for credits on benefit waiting periods of pre-existing conditions and to coordinate with your other insurance carriers to ensure that we pay your claims quickly and accurately.

If you need to provide us with additional information about other coverage (prior coverage or current other coverage), please obtain Prior Coverage Information Request forms or Multiple Coverage Inquiry forms from our Web site at <http://www.wa.regence.com/member/form/> or call our Customer Service department at **1-800-458-3523**.

PRIOR INSURANCE WITHIN THE PAST 6 MONTHS AND/OR CURRENT OTHER INSURANCE COVERAGE:

Prior or other Insurance Company Name: _____ Prior or other Insurance Company Phone #: _____

Prior or other Insurance Company Full Address: _____

Policyholder's Name: _____ Policyholder's Birth Date: _____ MMDDYYYY

Policyholder's Member ID # or Social Security #: _____ Group #/ Policy ID #: _____

Effective Date of Coverage: _____ Intended Termination Date of Coverage: _____ **Persons covered by prior or other insurance, please list names and birth dates:**

Name: _____ Birth Date: _____ MMDDYYYY Name: _____ Birth Date: _____ MMDDYYYY

Name: _____ Birth Date: _____ MMDDYYYY Name: _____ Birth Date: _____ MMDDYYYY

Type of Coverage (please circle): Medical Pharmacy Dental Vision Medicare **Type of Policy** (please circle): Group Individual Medicaid Medicare Part A Medicare Part B

Did your coverage include the following benefits (please circle): Chiropractic Maternity Prescription Drug Psychiatric Rehabilitation Transplants

If employee or dependents have Medicare, what was the begin date for Part A: _____ Part B: _____ Medicare HIC# with Alpha Suffix: _____

Name of Person covered by Medicare _____ Reason: Disability Over Age 65 End Stage Renal Disease

YOUR SPECIAL ENROLLMENT PERIOD RIGHTS For individuals who are eligible for enrollment in a group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage.) In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or within 60 days of birth, adoption, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. To request special enrollment or obtain more information, please contact your group administrator or benefits department.

APPLICATION AGREEMENT

I hereby apply for coverage under the contract between Regence BlueShield, which is an independent licensee of the Blue Cross Blue Shield Association, and my employer or group; and I agree with the terms of the contract. I also apply for the same coverage for my spouse/domestic partner and/or my dependent children listed on this application. I certify that my listed dependents and I meet the eligibility criteria set forth in the outline of benefits and/or the contract. I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases, as Regence BlueShield deems necessary.

RELEASE OF INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) 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.* Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes. *For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from our Web site at www.wa.regence.com or by phone at **1-800-458-3523** or **1-206-464-3663**.