



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Please complete all sections in black ink

EMPLOYEE ENROLLMENT & CHANGE FORM

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 Registered Domestic Partner
Non-Registered Domestic Partner\*

Date of Marriage/Domestic Partnership:

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

\*Non-Registered Domestic Partners must complete an Affidavit of Domestic Partnership.

This Section for Regence BlueShield Use Only - RIQ Code:
Rel ICN#:
ACRW Loaded: COB Loaded: Date Completed: M.A Initials:

A Reason Must be Checked for Add, Change, or Cancellation:
Add employee with/without dependent(s)
Add due to:
New group Open enrollment changes New employee
Birth Marriage Adoption COBRA coverage exhausted
Loss of eligibility on another coverage
Add DP (domestic partner) and dependent(s)
Add dependent(s) only, of DP (domestic partner)
Name change Address change Personal Care Provider change
Add to COBRA Effective date:
Add to 6-month extension Effective date:
Add to USERRA Extension: Effective date:

CANCELLATIONS:
List names below:
Employee and dependent(s)
Dependent(s) only
Intended termination date:
Select cancel reason:
TE = Termination
RH = Reduction in hours
DC = Dependent child(ren)
DV = Divorced
DE = Death
DX = Disability extension
MI = Medicare ineligible
CE = Voluntary cancellation of COBRA coverage
= Military Deployment

Select Plan: PPO Selections Traditional Medical HSA-Healthplan Columbia Dental Traditional Dental Other:

Table with 9 columns: Medical/Dental, Relationship, Name, Social Security Number, Birth Date, Gender, Personal Care Provider, PCP Rider #, Current Patient. Includes checkboxes for Employee, Spouse/DP\*, Child.

\*Non-Registered Domestic Partners must complete an Affidavit of Domestic Partnership.
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?
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?
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.

EMPLOYEE RELEASE AND AUTHORIZATION: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.
EMPLOYEE'S SIGNATURE: DATE: SPOUSE/DP'S SIGNATURE: DATE:

EMPLOYER SECTION: The Employer section must be completed by the Group Administrator or Group's Primary Contact Person; 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: Hours Worked Per Week:
Date of Hire: Rehire Date: Date Changed from Part-time to Full-time:



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# EMPLOYEE ENROLLMENT & CHANGE FORM

## 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 or if prior coverage has ended, attach a certificate of coverage from the prior insurance carrier. 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 # or Policy ID #: \_\_\_\_\_ Effective Date of Other/Prior Coverage: \_\_\_\_\_

Will coverage remain in effect?  Yes  No Date Coverage Ended or Will Be Ending: \_\_\_\_\_ 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 Medicare Part D

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: \_\_\_\_\_ Part D: \_\_\_\_\_ Medicare HIC# with Alpha Suffix: \_\_\_\_\_

Person covered by Medicare Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ 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/DP) 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, domestic partnership, 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.

### APPLICATION AGREEMENT

For the protection of all of our members, fraud or misrepresentation of material fact by you and/or the Group for the purposes of defrauding Regence BlueShield may result in Regence BlueShield taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, Regence BlueShield will have the right to collect any claims payments or other damages.

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 have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. 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](http://www.wa.regence.com) or by phone at 1-800-458-3523 or 1-206-464-3663.