



Large Group Health/Dental Application Without Health Statement

Requested Effective Date (subject to BCI approval) _____

Group Number _____

- PPO Medical Traditional Medical Managed Care Medical
 HSA PPO Dental Traditional Dental
 Dental Blue Connect

Please complete each section of this application in ink.

Applicant Information (Employee)					
Your Name (first, initial, last)		Blue Cross ID No. (if currently enrolled)	Social Security No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City, State, Zip Code		Phone Number ()	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Full-time Hire Date	Name of Employer	Job Title	Email Address	

Dependent Information							
List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).							
	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight	Male/Female	Type of Enrollment
Applicant/Employee	/ /	SELF	/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) (For the highest benefit level, you must select a PCP)						Office Use (PCP)
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) (For the highest benefit level, you must select a PCP)						Office Use (PCP)
Dependent's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female	Enroll in Medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Dental..... <input type="checkbox"/> Yes <input type="checkbox"/> No Enroll in Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) (For the highest benefit level, you must select a PCP)						Office Use (PCP)

Do you or any of your family members have other medical and/or dental coverage? YES NO
Coordinating your insurance benefits could reduce the amount you owe a provider.

Current/Prior Coverage (For proper crediting of pre-existing condition waiting periods AND Coordination of Benefits, please complete the section below. Use extra paper if necessary).

If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a **Certificate of Creditable Coverage** from your prior carrier or other appropriate documents to establish prior creditable coverage. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is primary (**please use additional paper if needed**).

To reduce the 12-month exclusion period by your creditable coverage, you should give your carrier a copy of any **Certificates of Creditable Coverage** you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage.

Other Carrier Information: Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Coverage End Date (mm/dd/yy)	Type of Coverage	Will this coverage continue?	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please read the reverse side and sign and date this application.

OVER →

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550

Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Auditor _____

Are you or any of your dependents currently disabled? YES NO (If YES, complete information below.)

Nature of Disability _____

Name of Disabled Person _____

Physician's Name _____

Physician's Phone Number _____

Date of Disability _____

Physician's Address _____

Type of Enrollment

Change Request

Health Coverage (check one)	Dental Coverage (check one, if applicable)	Vision Coverage (check one, if applicable)
<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self
<input type="checkbox"/> Self and spouse	<input type="checkbox"/> Self and spouse	<input type="checkbox"/> Self and spouse
<input type="checkbox"/> Self, spouse and dependents	<input type="checkbox"/> Self, spouse and dependents	<input type="checkbox"/> Self, spouse and dependents
<input type="checkbox"/> Self + 1 dependent	<input type="checkbox"/> Self + 1 dependent	<input type="checkbox"/> Self + 1 dependent
<input type="checkbox"/> Self + 2 or more dependents	<input type="checkbox"/> Self + 2 or more dependents	<input type="checkbox"/> Self + 2 or more dependents

Please indicate reason for change in current enrollment below:

Involuntary loss of group coverage Marriage

Birth Adoption

Court order (copy of court order required)

Other _____

Date event occurred ____/____/____

Statement of Understanding

By signing this application, I represent that all my answers in this application are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of the insurer, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcidaho.com.
- **NOTICE OF PREEXISTING CONDITION EXCLUSION:** This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a specified period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends on the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends the day before the waiting period begins. This preexisting condition exclusion does not apply to pregnancy nor to individuals under the age of 19 years beginning upon the Employer Group renewal on or after September 23, 2010, as provided in the Patient Protections and Affordable Care Act (PPACA).

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

- A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X _____
Applicant's Signature

Date

This application must be signed and dated.