



# Large Group Health Application Without Health Statement

Requested Effective Date (subject to BCI approval) \_\_\_\_\_

Group Number \_\_\_\_\_

- PPO   
  HSA Blue<sup>SM</sup> PPO   
  HSA Blue<sup>SM</sup> POS  
 Traditional   
  Managed Care POS

Please complete each section of this application in ink.

<b>Applicant Information (Employee)</b>					
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	
<b>For Managed Care Plans Only</b>		Name of Primary Care Physician (PCP) or PCP ID Number	Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Office Use Only PCP</b>	

<b>Dependent Information</b>					<b>For Managed Care Plans Only</b>		
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)		Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level you must select a PCP)	Existing Patient of PCP?	Office Use Only PCP
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Current/Prior Coverage (For Coordination of Benefits, please complete the section below. Use extra paper if necessary).</b>						
Do you or any of your family members have other medical and/or dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Coordinating your insurance benefits could reduce the amount you owe a provider. For proper coordination of benefits please complete the section below. 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.						
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?
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<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"/> Medical <input type="checkbox"/> Dental	<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"/> Medical <input type="checkbox"/> Dental	<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	Effective Date	Plan ID			Class	Reason Code
			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 \_\_\_\_\_

<b>Type of Enrollment</b>	<b>Change Request</b>
<b>Health Coverage (check one)</b> <input type="checkbox"/> Self <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and dependents <input type="checkbox"/> Self and 1 dependent <input type="checkbox"/> Self and 2 or more dependents	<b>Please indicate reason for change in current enrollment below:</b> <input type="checkbox"/> Involuntary loss of group coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court order (copy of court order required) Other _____ Date event occurred _____ <div style="text-align: center;">mm      dd      yy</div>

**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 [bcidaho.com](http://bcidaho.com).

- 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.**