For Office Use Only

Requested Effective Date: _____

Location Number: _____

Health/Dental and Vision Form

Please complete each section of this application in ink.

Applicant Information (employee)

Your Name (first, initial, last)	Social Security No.	Date of Birth	❑ Male ❑ Female
	- -	/ /	
Mailing Address	City, State, Zip Code	Phone Number ( )	
Full-time Hire Date	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Other	Store Number or Location	Job Title

Family Information List all family members you wish to enroll in Medical and Vision. Children must be under 23, never married and dependent on you for support.

Family Member's Name (first, initial, last)	Social Security No.	Relationship (spouse, child, stepchild, domestic partner, etc.)	Date of Birth	Coverage Type	Sex
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F
	- -		/ /	❑ Medical ❑ Vision	❑ M ❑ F

Type of Enrollment	Type of Enrollment	Change Request
Health/Dental Coverage (check one)	Vision Coverage (check one)	Change Current Enrollment (because of the following event)
❑ Self	❑ Self	❑ Marriage ❑ Divorce
❑ Self and Spouse/Domestic Partner	❑ Self and Spouse/Domestic Partner	❑ Birth ❑ Involuntary loss of coverage
❑ Self, Spouse/Domestic Partner and Children	❑ Self, Spouse/Domestic Partner and Children	❑ Death ❑ Other
❑ Self & 1 Child	❑ Self & 1 Child	❑ Court Order (copy of court order required)
❑ Self & 2 or More Children	❑ Self & 2 or More Children	Date of Event:_____
❑ Decline Medical	❑ Decline Vision	

Are you or any of your dependents currently disabled? ■ Yes ■ No (If yes, complete information below.)

Nature of Disability	Physician's Name	Physician's Phone Number ( )
Name of Disabled Person	Physician's Address:	
Date of Disability / /		

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

For Office Use Only

Group Number	Subgroup	HIPAA			Effective Date	Plan ID		LOC	Class	Reason Code
		Credit Days	Start	End		M	D			
10030052										

Auditor_____

Prior and/or Current Coverage Information

Please complete for proper crediting of waiting periods and coordination of benefits.

Is any person listed on this application now covered, or has he or she been covered, by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period)? ❑ Yes ❑ No

If **yes**, please complete all information below for each person listed on this application. (Use extra paper if necessary.)

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy Start Date: (mm/dd/yy)	Date of Policy End Date (mm/dd/yy)	Will Current Policy Continue?
Employee						❑ Yes ❑ No
Spouse						❑ Yes ❑ No
Child						❑ Yes ❑ No
Child						❑ Yes ❑ No
Child						❑ Yes ❑ No

If any person listed on this application is covered by Medicare, please complete the following:

Name:	Medicare Beneficiary Number:	Reason for Medicare Entitlement: (age, disability or ESRD)
Date of Medicare Entitlement	PART A: (mm/dd/yy) / /	PART B: (mm/dd/yy) / /

• If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your certificate of health coverage; this will ensure proper credit for any preexisting conditions, if applicable.

• If your coverage is terminated, please state reason: _____

_____

• If your current coverage will remain active, please indicate if coverage is for: ❑ Medical ❑ Dental ❑ Vision

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:

• 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 purposes 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.

• Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition. A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advise, 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 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 for at least 12 months, you are entitled to receive a Certificate of Credible Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of the coverage for you and 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 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.