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

Regence BlueShield of Idaho
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

Application For Enrollment/Change (for self-insured groups)

Please print in black ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned**. The five boxes directly below should be completed by the Group Administrator.

Please submit this completed form to Human Resources. If enrolling dependents, proof of dependent eligibility and/or qualifying life event is required. For example, marriage certificate, birth certificate, notice of loss of coverage, etc. Enrollment changes must be made within specific timeframes dependent on the qualifying life event. Please contact Human Resources if you have any questions.

Health Group Number	Group Name	Requested Effective Date
1 0 0 0 6 0 0 6	**City of Lewiston**	

Class

☐ 0001-Active ☐ 0002-COBRA ☐ 0003-Firefighters ☐ 0004-Retirees

Subgroup

☐ 0001-City of Lewiston Active ☐ 0002-City of Lewiston COBRA ☐ 0003-Retirees

Employee Last Name	First Name	Middle Initial

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:
☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date ________________
☐ Eligibility Waiting Period Start Date ________________

CHANGE

Change:
☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Reason for change*____
Reasons include: birth, marriage/eligible domestic partner, divorce, death, adoption, dependent change (add or drop), involuntary loss of other coverage.

Date of Change Event

Demographic Information Change: ☐ Name Change ☐ Address Change ☐ Other:________________

CANCELLATION AND/OR COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)
☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)
☐ Cancel Dependent(s) - List: ____

COBRA Enrollment: ☐ COBRA

Reason for COBRA Entitlement* ________________________________
Reasons include: Enrolled child no longer eligible, Medicare Entitlement, Reduction of Hours, Divorce/Termination of Domestic Partnership, Death, Termination of employment.

Date of Cancellation Event

SECTION 2 - PLAN SELECTION

MEDICAL: $1,500 Deductible - $3,000 Out of Pocket Max - 80%/50%/50%, Office Visit Copay - PCP $30 / Specialist $50
RX: $10 Tier 1 / 25% up to$100 maximum Tier 2 / 50% up to $200 maximum Tier 3 / 50% up to $300 Tier 4

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SECTION 3 - EMPLOYEE INFORMATION

Mailing Address		City, State, and ZIP Code	
Physical Address ☐ Same as Mailing Address		City, State, and ZIP Code	
Date of Birth	Hours Per Week	Primary Language	Full-time Date of Hire
Gender: ☐ Female ☐ Male	Social Security Number	Daytime Telephone Number	Original Date of Hire

Marital Status: ☐ Single ☐ Divorced ☐ Married or Registered Domestic Partner ☐ Non-Registered Domestic Partner
*** Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.**

What type of member card would you like to receive?
☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

Go paperless! Regence can send secure communications about your insurance claims and benefits to a Regence.com account! Once registered, an email or text (your choice) will notify you when a new communication is posted. Yes, please set up an account for me and email me a link to access and personalize it.

My email address: ____

SECTION 4 - ENROLLING DEPENDENTS

Gender	Dependent Name (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number	Birthdate Mo/Day/Yr
☐ F ☐ M		☐	☐			
☐ F ☐ M		☐	☐			
☐ F ☐ M		☐	☐			
☐ F ☐ M		☐	☐			

If you need extra space, please request an additional form from your group administrator.

SECTION 5 - CURRENT AND PRIOR COVERAGE

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of any court documentation that shows who is responsible for the health care insurance of the dependent(s) so that the carrier can determine which coverage should pay first.

Name of Covered Members and Policy Information	Will Coverage Continue?	Product and Coverage Type
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ Part A ☐ Part B ☐ Part D
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

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Applicant signature

I certify that all information provided on this form is true, correct, and complete. In addition, I have reviewed and agree to the provisions set out in the Acknowledgments and Authorizations section below.

Applicant Signature:____ Date: ________________

SECTION 6 - ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. Any coverage will be under the master contract between Regence and my employer and subject to the terms and conditions of the certificate issued under it. I agree to the Employer's enrollment provisions and certify that those I seek to enroll meet the eligibility criteria. I understand that coverage does not start until I serve the employer's eligibility waiting period established in Regence's records.

I waive coverage of any eligible individual not listed on this application. I understand that a waiver form must be completed for those individuals who choose not to enroll at this time. I, or any other waived individual, may enroll at a later time during my group's anniversary or a Special Enrollment Period. If I waive enrollment for myself or any of my dependents because of other health insurance coverage, I may enroll the waived individuals if I request enrollment within 30 days after the other coverage ends. In addition, I may enroll myself and or new dependents within 60 days of marriage or domestic partnership, or within 60 days of birth, adoption, or placement for adoption. Please call 1 (800) 505-6801 for more information about these rules.

This application will become part of the contract between Regence and my employer and I understand only an officer of Regence may change the terms of the master contract, its amendments, or this application. I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way an agent for Regence. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Regence, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence may request or disclose health information, other than psychotherapy notes (for which a separate authorization will be used), about me or my enrolled dependents from time to time to facilitate health care treatment or payment, to assist with business operations necessary to administer health care benefits, or as required by law. More information about Regence's uses and disclosures of information is provided in its Notice of Privacy Practices, available at regence.com or by calling customer service.

I understand there may not be participating providers in all specialty areas.

I certify that all information provided on this form is true, correct, and complete, and understand Regence will rely on it in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance and/or benefits.

Regence BlueShield of Idaho: 1602 21st Avenue, Lewiston, Idaho 83501

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