



# MEMBERSHIP APPLICATION

(Fifty or Fewer Eligible Employees)

**INSTRUCTIONS:**  
1. PRINT HARD WITH BLACK BALLPOINT PEN OR TYPE.  
2. COMPLETE AND SIGN APPLICATION.  
3. BLUECHIP COORDINATED HEALTH PLAN (BLUECHIP) ENROLLEES: SELECT A PCP FOR EACH MEMBER IN ITEMS 28 - 30.

DO NOT WRITE IN THIS AREA

|  |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--------------------------|--|---|--|--|--|---------------------------|---|--------------------|---|--|--|--|---|--|--------------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> A1 GROUP <input type="checkbox"/> A2 SUBGRP <input type="checkbox"/> A3 CK <input type="checkbox"/> A4 LID  |  |  |                          |  |   |  |  |  |                           | APPLICATION RECEIVED DATE   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 1 PLAN <input type="checkbox"/> HEALTHMATE COAST-TO-COAST <input type="checkbox"/> HEALTHMATE COAST-TO-COAST HDHP<br>DESIRED: <input type="checkbox"/> BLUESOLUTIONS FOR HRA <input type="checkbox"/> BLUESOLUTIONS FOR HSA <input type="checkbox"/> BLUECHIP<br>Covering: <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee & Spouse <input type="checkbox"/> Enrollee & Children <input type="checkbox"/> Enrollee, Spouse & Children |  |  |                          |  |   |  |  |  |                           | DENTAL BENEFITS <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Covering: <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee & Spouse<br><input type="checkbox"/> Enrollee & Children<br><input type="checkbox"/> Enrollee, Spouse & Children |                    |   |  |  | 2 APPLICATION TYPE<br><input type="checkbox"/> NEW<br><input type="checkbox"/> CHANGE<br><input type="checkbox"/> TRANSFER   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 3 EMPLOYER (GROUP) NAME  |  |  |                          |  | 4 GROUP NUMBER                            |  |  |  |                           | 5 EFF. DATE OF COVERAGE   |                    |   |  |  | 6 FOR MEMBERSHIP USE ONLY<br>CONTRACT TYPE    PACKAGE  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 7 LAST NAME  |  |  | 8 FIRST                  |  |   | 9 INITIAL  |  |  | 10 TITLE (JR, MD, ETC)    |   |                    | 11 GENDER<br>MALE <input type="checkbox"/><br>FEMALE <input type="checkbox"/> |  |  | 12 CHECK MARITAL STATUS<br>SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/><br>WID <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/><br>COMMON LAW <input type="checkbox"/> |   |  | 13 BIRTHDATE<br>MONTH    DAY    YEAR |  |  |  |  |  |  |  |  |  |  |  |
| 14 RESIDENCE ADDRESS STREET, BOX, RT. NO.  |  |  |                          |  | 15 ADDITIONAL ADDRESS (APT., BLDG., ETC.) |  |  |  |                           | 16 CITY   |                    |   | 17 STATE   |  |  | 18 ZIP  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 19 HOME TELEPHONE (with area code)   |  |  | 20 DATE OF HIRE          |  |   | 21 OCCUPATION  |  |  |                           |   | 22 EMPLOYEE NUMBER |   |  |  |  | 23 PRIMARY LANGUAGE SPOKEN                                |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 24 NAME (LAST) (FIRST) (MI)  |  |  | 25 BIRTHDATE MO. DAY YR. |  |   | 26 SEX RELATIONSHIP  |  |  | 27 SOCIAL SECURITY NUMBER |   |                    | 28 **MANDATORY FOR BLUECHIP COVERAGE<br>PERSONAL CARE PHYSICIAN (PCP)         |  |  | 29 ARE YOU A CURRENT PATIENT?  |   |  | 30 PCP NUMBER                        |  |  | 31 IF STUDENT NAME OF COLLEGE    Admission Mo. Yr. |  |  |  |  |  |  |  |  |
| Please Do Not Write In Shaded Area.  |  |  |                          |  |   | SUBSCRIBER   |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  | Please Do Not Write In Shaded Areas.   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |                          |  |   | <input type="checkbox"/> M SPOUSE<br><input type="checkbox"/> F    |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |                          |  |   | <input type="checkbox"/> M DEPENDENT<br><input type="checkbox"/> F |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |                          |  |   | <input type="checkbox"/> M DEPENDENT<br><input type="checkbox"/> F |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |                          |  |   | <input type="checkbox"/> M DEPENDENT<br><input type="checkbox"/> F |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |                          |  |   | <input type="checkbox"/> M DEPENDENT<br><input type="checkbox"/> F |  |  | FIRST NAME    LAST NAME   |   |                    | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| <b>Other Insurance Information</b>   |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  | <b>**APPLICATION CANNOT BE COMPLETELY PROCESSED WITHOUT SELECTION OF PCP</b>   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 32 IF YOU OR ANY OF YOUR DEPENDENTS ARE ENROLLED IN ANOTHER INSURANCE PLAN, IS COVERAGE FOR    HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/>   |  |  |                          |  |   |  |  |  |                           | 33 RELATIONSHIP   |                    |   |  |  | 34 POLICY/CONTRACT #   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 35 NAME OF POLICY HOLDER WITH OTHER INSURANCE  |  |  |                          |  |   |  |  |  |                           | 36 NAME AND ADDRESS OF OTHER INSURANCE CO./OTHER PLAN   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 37 IS ANYONE NAMED IN THIS APPLICATION ELIGIBLE FOR MEDICARE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO    NAME OF ELIGIBLE PERSON   |  |  |                          |  |   |  |  |  |                           | 38 REASON FOR ELIGIBILITY<br><input type="checkbox"/> OVER 65<br><input type="checkbox"/> DISABILITY  |                    |   | 39 MEDICARE A (HOSPITAL) EFFECTIVE DATE<br>MO    DAY    YR |  |  | 40 MEDICARE B (MEDICAL) EFFECTIVE DATE<br>MO    DAY    YR |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| <b>CHANGE FROM SINGLE PLAN TO FAMILY PLAN</b>  |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  | <b>CHANGE FROM FAMILY PLAN TO SINGLE PLAN</b>  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 41 <input type="checkbox"/> MARRIAGE    DATE OF MARRIAGE    SPOUSE'S FORMER LAST NAME  |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  | 45 <input type="checkbox"/> DIVORCE    46 DATE OF CHANGE   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 42 <input type="checkbox"/> ADDITION OF DEPENDENTS <input type="checkbox"/> CANCELLATION OF DEPENDENTS<br>(complete dependent section above)   |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  | 47 <input type="checkbox"/> DEATH OF SPOUSE<br><input type="checkbox"/> SEPARATED<br><input type="checkbox"/> OTHER (specify)    /    /    /   |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 43 <input type="checkbox"/> NAME CHANGE    FORMER NAME    44 <input type="checkbox"/> MILITARY REINSTATEMENT    DATE OF ENTRY    DATE OF DISCHARGE   |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 43 <input type="checkbox"/> ADDRESS CHANGE (complete address section above)  |  |  |                          |  |   |  |  |  |                           |   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 47 NAME UNDER WHICH CURRENT CONTRACT IS LISTED   |  |  |                          |  |   |  |  |  |                           | 48 CURRENT IDENTIFICATION NO.   |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |
| 49 CURRENT GROUP NO.   |  |  |                          |  |   |  |  |  |                           | 50 ARE YOU TRANSFERRING FROM ANY OF THE FOLLOWING?<br><input type="checkbox"/> BLUE CROSS AND BLUE SHIELD <input type="checkbox"/> OTHER  |                    |   |  |  |  |   |  |                                      |  |  |  |  |  |  |  |  |  |  |  |

I hereby authorize any physician, hospital, other medical facility or provider to release to Blue Cross & Blue Shield of Rhode Island any and all records, opinions, reports, x-rays, laboratory tests, analysis or other information of any kind relating to myself or my minor dependents which is requested or received while such persons are covered by health insurance from Blue Cross & Blue Shield of Rhode Island. Blue Cross & Blue Shield of Rhode Island may use this information for purposes of claims payment, case management, coordination of benefits, and other purposes directly related to the administration of Blue Cross & Blue Shield of Rhode Island. This authorization shall expire two (2) years from the issue date of this policy, unless sooner revoked.

I certify the information is true and complete to the best of my knowledge.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Employee Copy may be used as temporary evidence of coverage for 30 days from the date below if authorized by employer.**

EMPLOYER VERIFICATION: \_\_\_\_\_ DATE \_\_\_\_\_

White - Membership Dept.    Gold - Marketing    Yellow - Employer    Pink - Employee

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.