



## Large Group Health Application Without Health Statement

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

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

Please complete each section of this application in ink.

PPO       Traditional       Managed Care

<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 (    ) (    ) (    )	
Full-time Hire Date	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Name of Employer		Job Title	
<b>For Managed Care Plans Only</b>		Name of Primary Care Physician (PCP)	Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Office Use Only PCP</b>

<b>Family Member Information</b>						
List all family members you wish to enroll. Children must be under 23, never married, and dependent on you for support.					<b>For Managed Care Plans Only</b>	
Family Member's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Primary Care Physician (PCP) <small>(For the highest benefit level you must select a PCP)</small>	Existing Patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Prior and/or Current Coverage Information</b> (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)? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If <b>YES</b> , please complete all information below for <b>each</b> person listed on this application.							
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee							
Spouse							
Child							
Child							
Child							

(Please use extra paper if necessary.)

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	Part B	
	mm / dd / yy	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    Termination Date \_\_\_\_\_

<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 children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children	<b>Change current enrollment because of the following event:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____ Date event occurred _____ / _____ / _____ <div style="text-align: center; font-size: small;">mm    dd    yy</div>

**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 \_\_\_\_\_

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		

## 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 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](http://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 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 for at least 12 months, 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.**