



# 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 DESIRED: <input type="checkbox"/> BLUESOLUTIONS FOR HRA <input type="checkbox"/> BLUESOLUTIONS FOR HSA <input type="checkbox"/> CLASSIC <input type="checkbox"/> BLUECHIP <input type="checkbox"/> BLUECHIP										DENTAL BENEFITS <input type="checkbox"/> YES <input type="checkbox"/> NO Covering: <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee & Spouse <input type="checkbox"/> Enrollee & Children <input type="checkbox"/> Enrollee, Spouse & Children					2 APPLICATION TYPE <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER														
3 EMPLOYER (GROUP) NAME					4 GROUP NUMBER					5 EFF. DATE OF COVERAGE					6 FOR MEMBERSHIP USE ONLY CONTRACT TYPE    PACKAGE														
7 LAST NAME			8 FIRST			9 INITIAL			10 TITLE (JR, MD, ETC)			11 GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>			12 CHECK MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WID <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/> COMMON LAW <input type="checkbox"/>			13 BIRTHDATE 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 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 <input type="checkbox"/> NO			Please Do Not Write In Shaded Areas.														
						SPOUSE			FIRST NAME    LAST NAME			<input type="checkbox"/> YES <input type="checkbox"/> NO																	
						DEPENDENT			FIRST NAME    LAST NAME			<input type="checkbox"/> YES <input type="checkbox"/> NO																	
						DEPENDENT			FIRST NAME    LAST NAME			<input type="checkbox"/> YES <input type="checkbox"/> NO																	
						DEPENDENT			FIRST NAME    LAST NAME			<input type="checkbox"/> YES <input type="checkbox"/> NO																	
						DEPENDENT			FIRST NAME    LAST NAME			<input type="checkbox"/> YES <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 <input type="checkbox"/> OVER 65 <input type="checkbox"/> DISABILITY			39 MEDICARE A (HOSPITAL) EFFECTIVE DATE MO    DAY    YR			40 MEDICARE B (MEDICAL) EFFECTIVE DATE 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 <input type="checkbox"/> DEATH OF SPOUSE <input type="checkbox"/> SEPARATED <input type="checkbox"/> OTHER (specify)    /    /														
42 <input type="checkbox"/> ADDITION OF DEPENDENTS <input type="checkbox"/> CANCELLATION OF DEPENDENTS (complete dependent section above)																													
43 <input type="checkbox"/> NAME CHANGE    FORMER NAME <input type="checkbox"/> ADDRESS CHANGE (complete address section above)										44 <input checked="" type="checkbox"/> MILITARY REINSTATEMENT    DATE OF ENTRY    DATE OF DISCHARGE																			
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? <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

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