Regence

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

State of Idaho
Medical Enrollment Application

If you have questions, contact:
Department of Administration
Office of Group Insurance
208-332-1860 or 1-800-531-0597
ogi@adm.idaho.gov

Date of Application (mm/dd/yyyy): _____

Effective Date (mm/dd/yyyy): _____

Group Number	Subgroup	Class
10060598		

POLICY TYPE (please check one)[1]: ☐ **PPO** ☐ **Traditional** ☐ **High Deductible Health Plan (HDHP)[2]**

[1] Medical policy includes vision, prescription drug, and EAP.

[2] If enrolling in the HDHP, will you also enroll in the State of Idaho-sponsored Health Savings Account? ☐ Yes ☐ No

SECTION 1 – NEW ENROLLMENT, CHANGE OR TERMINATION (Please populate all fields)

State Agency or School District	Employment Type	Original Date of Hire	Rehire Date
	☐ Full-time ☐ Part-time		

Employee Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	Gender
		☐ Male ☐ Female ☐ Non-binary/Other

Employee Mailing Address	City	State	ZIP

Daytime Phone Number	Email Address - to receive important information	Primary Language	Marital Status
			☐ Single ☐ Married ☐ Divorced

Complete only to decline benefits as a New Hire (Do not complete the information below this box.) I hereby decline all benefits. I understand that benefits may be added during open enrollment or following a qualifying life event, as outlined in the State of Idaho member contract.

Signature: _____ **Date:** _____

Enrollment/Benefit Change Request

1. Are you enrolling/disenrolling during your employer's specified Open Enrollment period? ☐ Yes ☐ No

2. Are you making enrollment changes? If you are making enrollment changes outside of Open Enrollment, mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) _____

☐ New Hire ☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Death ☐ Gain of Other Coverage ☐ Overage Dependent ☐ Court Order
☐ Employment Status Change (FT>PT; PT>FT) ☐ Gain Eligibility (eg.,ACA Required Coverage) ☐ Involuntary loss of Group, Individual or Medicaid coverage

Provide name of carrier _____ Last Day of Coverage: _____

3. Are you transferring to a new agency or school district who participates in the State's Health Plan? ☐ Yes ☐ No Transfer date: _____

Transferring to: _____ Transferring from: _____

SECTION 2 – ENROLLING DEPENDENTS

Spouse & Eligible Children to be Enrolled *(list everyone you wish to enroll, disenroll, or keep on the plan with no changes)*

Name (first, middle, last)	Relationship	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Coverage Updates
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes

*O = Non-binary/Other

Is your spouse an employee of a state agency or school district that participates in the State of Idaho Health Plan? ☐ YES ☐ NO

If YES, spouse's name: _____ Spouse's Social Security Number: _____

State Agency/School District: _____

Important: Spouse must complete a separate application to enroll or to decline coverage. **Participants cannot be actively enrolled more than once on the State of Idaho Health Plan.**

Regence BlueShield of Idaho, Inc.

SECTION 3 – CURRENT AND PRIOR COVERAGE (Please complete for proper coordination of benefits administration.)

Is any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Shield of Idaho policy?

☐ YES ☐ NO If **YES**, please complete all information below for **each** person listed on this application.

Name of Covered Member(s)	Name of Carrier	Policy Number	Type of Policy	Policy Start Date (mm/dd/yyyy)	Will Policy Continue?†
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO

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

†If your current coverage will be terminated, please indicate termination date (mm/dd/yyyy): _____

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

Name	Medicare	Reason for Medicare Entitlement
	☐ Part A ☐ Part B ☐ Part D	☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

SECTION 4 – DISABILITY INFORMATION

Total disability is a condition resulting from disease or accidental injury, as certified in writing by an attending physician, that renders the enrollee/member incapable of performing the principal duties of regular employment/occupation for which he/she is qualified/trained and he/she is not engaged in any work, profession or avocation for fees, gain or profit; or he/she is unable to engage in the normal activities of an individual of the same age and gender.

Are you or any of your dependents currently totally disabled? ☐ Yes ☐ No *(If YES, complete information below.)*

_____

Nature of Total Disability

_____ _____ _____

Name of Totally Disabled Person *Physician's Name* *Physician's Phone Number*

_____ _____

Date of Total Disability *Physician's Address*

SECTION 5 – ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or termination 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 annual open enrollment period 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 or new dependents within 60 days of marriage, 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, 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 purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance or benefits.

SECTION 6 – APPLICANT SIGNATURE

I have reviewed and agree to the provisions set out in Section 5 – Acknowledgments and Authorizations above.

Applicant Signature: _____ Date: _____

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