

Statewide Schools ASC Health/Dental/Vision **Enrollment Application**

Requested Effective Date (subject to Blue Cross of Idaho approval)_ Group Number __ ☐ HSA BlueSM PPO ☐ PPO Medical ☐ Managed Care Medical POS ☐ HSA BlueSM POS ☐ PPO Dental ☐ Traditional Dental ☐ Dental Blue Connect □ Vision

Please complete each	section of th	is applicat	ion in in	ık.						
Applicant Inform	ation (Emp	oloyee)								
Your Name (first, initial, last)					Blue Cross ID No. (if currently enrolled	Social Secur	ecurity No. Date of Birth		Birth	☐ Male ☐ Female
Mailing Address					City, State, Zip Code		Phone Number			
Marital Status Full □ Single □ Married □ Divorced □ Widowed	Name of Employer			JobTitle		Email Address				
Dependent Infor	mation //f you	shoose not to	oproll all w	our oligible family me	mbore you must some	oloto a waiver form \	•			
List all eligible dependents y required).							endent on paren	nt for sup	oport (copy of	certification
	Social Security Relationship (spouse, child, Number Stepchild, etc.) Relationship (spouse, child, (mm/dd/yy) Male/Female				Type of Enrollment					
Applicant/Employee			SELF		□ Male □ Female	Enroll in Medical Yes Enroll in Dental Yes Enroll in Vision Yes			🖵 Yes 🖵 No	
For Managed Care Plans Only		Name of Primary Care Physician (PCP) or PCP ID must select a PCP)			Number (For the highes	t benefit level, you	Existing Patient? Use (PCP)			
Dependent's Name (first, initial					□ Male □ Female				🖵 Yes 📮 No	
For Managed Care Plans Only		Name of Prima must select a P		rsician (PCP) or PCP ID	Number (For the highes	t benefit level, you	Existing Pa		Office Use (PCP)	
Dependent's Name (first, initial, last)						□ Male □ Female	Enroll in Der	ntal		
For Managed Care Plans Only		Name of Prima must select a P		rsician (PCP) or PCP ID	Number (For the highes	t benefit level, you	Existing Pa		Office Use (PCP)	
Dependent's Name (first, initial, last)						□ Male □ Female	Enroll in Der	ntal		
For Managed Care Plans Only		Name of Prima must select a P		rsician (PCP) or PCP ID	Number (For the highes	t benefit level, you	Existing Pa		Office Use (PCP)	
Dependent's Name (first, initial, last)						□ Male □ Female	Enroll in Der	ntal		
For Managed Care Plans Only		Name of Primary Care Physician (PCP) or PCP ID must select a PCP)			Number (For the highes	Existing Pa		Office Use (PCP)		
Dependent's Name (first, initial, last)						□ Male □ Female	Enroll in Der	ntal		
For Managed Care Plans Only		Name of Primary Care Physician (PCP) or PCP ID must select a PCP)			Number (For the highes	Existing Pa		Office Use (PCP)		
Type of Enrollment					Change Req					
Health Coverage	•		Vision Coverage		Please indicate reason for change in current enrollment below:					
(check one) (check one) □ Self only □ Self only		<i>(check one)</i> □ Self only		□ Involuntary loss of group coverage □ Marriage □ Birth □ Adoption						
□ Self and spouse □ Self and spouse		·		□ Court order (copy of court order required)						
□ Self, spouse and dependents □ Self, spouse and dependents		nd Self, spouse and dependents		Other						
☐ Self and one dependent ☐ Self and one dependent ☐ Self and two or more dependents ☐ Self and two or dependents		dependent		Date event occurred mm dd yy						

Please read the reverse side and sign and date this application.

OVER 🖝

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date		Plan ID		Class	Reason Code
			М	D	V		

Auditor __

Hea	Ith Statement (Complet	te this healt	n statement if you a	apply for c	coverage for yourself or a f	family membe	r after the ori	ginal eligibility perio	od.)
not	e you or any family membe yet had? es □ No	r listed on	this application ev	ver been a	advised to have any surg	gical operatio	n(s) that you	u or any family me	mber have
hea	you or any family member lth, regardless of whether a es 📮 No						esses or othe	er departures from	good
take	ing the past 12 months, haven any prescribed medications \(\textstyle \texts		ny family member	· listed on	this application receive	ed a prescript	ion for medi	cation from a phys	sician or
	you or any family member es 👊 No 🏻 If pregnant, wha				nt?			_	
	e you or any family membe es □ No	er listed on	this application ev	/er been	refused or issued restric	eted health ins	surance cove	erage?	
	e you or any family membe es □ No	er listed on	this application be	en hospi	italized during the last 5	years?			
	in the past two years, have s □ No	you or any	member of your	family be	en treated for back/joint	t disorder?			
alco or n	e you or any family membe hol/drug use or abuse, can ervous disorders or respira es • No	cer, heart p	roblem/disorder, d						
If you	checked YES to any questio	n above, pl	lease provide deta	ils below	ı (please use extra paper i	if necessary):			
Item No.	Person Affected	Mo./ Year	Name of Disease, S or Condition Include Type of Tre) —	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician
	any person listed on this ap one age 18 or older)? □ No	-	•		verage four or more tim	es a week wi	thin no long	er than the past six	x months
	rent/Prior Coverage (paper if nece	essary).	
Coord covera respor	u or any of your family mer inating your benefits could age is provided for a depend sible for the dependent(s)'	reduce the dent from a	amount you owe a	a provide je or relat	er. For proper coordinati tionship, please attach a	copy of the coverage is	primary. Use	entation that show e extra paper if nec	s who is cessary.
	rher Carrier Information: ier Name, Policy Number, Phone Number	Policyh	nolder Name		s of Covered Members: lf and Dependent(s)	Coverage Start Date (mm/dd/yy)	Coverag End Da (mm/dd/	te Type of	Will <u>this</u> coverage continue?
								☐ Medical ☐ Dental	☐ Yes ☐ No
								☐ Medical ☐ Dental ☐ Medical	□ Yes □ No □ Yes
								□ Dental	□ No
								□ Dental	□ No

Disability Information							
Are you or any of your dependents currently disabled? YES NO							
	Nature of Disability						
Name of Disabled Person	Physician's Name Physician's Phone Number						
Date of Disability	Physician's Address						
Statement of Understanding							
By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:	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						
• I agree to abide by all of the terms and conditions of the group policy.	amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Blue						
 No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately. 	Cross of Idaho. • I agree that a facsimile or photocopy of my signature will serve the						
Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.	 same as an original. 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 						
Blue Cross of Idaho may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.	true and complete.						
 If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho. 	XApplicant's Signature						
• 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 <i>bcidaho.com</i> .	Date						