Regence

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

Regence BlueCross BlueShield of Oregon
100 SW Market Street
PO Box 1271
Portland, Oregon 97207-1271

Application For Enrollment/Change

Please print in black or blue ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.** The five boxes directly below should be completed by the Group Administrator.

Health Group Number	Subgroup	Group Name	Requested Effective Date	Class

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

New Enrollment:
☐ Applicant Only ☐ Applicant and Dependent(s)

New Enrollment due to:
☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date ________ ☐ COBRA ☐ Non-COBRA Continuation (For COBRA and Non-COBRA, a reason for cancellation must be selected below)

Product:
☐ Innova ☐ Engage ☐ Activate ☐ Regence HSA Healthplan 2.0 ☐ Preferred ☐ None

Dental:
☐ Encore ☐ Radiance ☐ Expressions ☐ None

If your Employer offers multiple medical or dental products with the same name, please provide the following information located at the top of your Benefit Summary.

Deductible $ ________ Coinsurance ______ / ______ / ______ % Copay $ ________

Change:
☐ Add applicant with/without dependent(s) ☐ Add dependent(s) only - Applicant must already be enrolled

Change due to:
☐ Name Change ☐ Address Change ☐ Birth ☐ Marriage ☐ Adoption ☐ Open Enrollment Changes
☐ COBRA Coverage Exhausted ☐ Loss of Eligibility on another plan ☐ Court Order ☐ Add Eligible Domestic Partner (DP)

Date of Change Event (required)

Cancellation:
☐ All Dependent(s) ☐ Cancel Dependent(s) - list:

Cancellation due to:
☐ Dependent no longer eligible ☐ Divorce, annulment, or termination of domestic partnership ☐ Medicare Entitlement
☐ Death ☐ Termination of Employment ☐ Reduction of Hours ☐ Military Leave ☐ Other reason ________

Date of Cancellation Event (required)

SECTION 2 - EMPLOYEE INFORMATION

Gender: ☐ Female ☐ Male

Marital Status: ☐ Married or Oregon-Certified DP ☐ Single ☐ Divorced ☐ Non-Certified DP

What type of member card would you like to receive? ☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

SECTION 3 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number for each individual covered	Birthdate Mo/Day/Yr
☐ M ☐ F		☐	☐			/ /
☐ M ☐ F		☐	☐			/ /
☐ M ☐ F		☐	☐			/ /
☐ M ☐ F		☐	☐			/ /
☐ M ☐ F		☐	☐			/ /
☐ M ☐ F		☐	☐			/ /

If you need extra space, please request an additional form from your group administrator.

Has any person listed on this application used tobacco during the past 12 months? If yes, list applicant's name(s): ________

If you or your spouse are divorced, legally separated, or if your domestic partnership is terminated, please indicate below who has legal custody of your child(ren):

SECTION 4 - CHILD CUSTODY INFORMATION

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Is the parent without custody required by court decree to provide coverage for the dependent children? Yes No If "Yes" list other coverage provided
________	☐	☐	☐	☐	________	☐ ☐ ________
________	☐	☐	☐	☐	________	☐ ☐ ________

SECTION 5 - CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE.

MEDICARE If you or any family members listed on this application have Medicare, is coverage ☐ **Part A** ☐ **Part B** ☐ **Part D,** and please complete the following information:

			Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ESRD ☐ Dual Entitlement
			Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ESRD ☐ Dual Entitlement

Applicant's Name (Non-Medicare)	**Insurance Carrier (Policy Number and Phone Number)**	**Date of Coverage Month/Day/Year**		**Will coverage continue?**	**Type of Coverage**
		From	**To**		
1.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
2.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
3.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
4.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
5.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
6.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical
7.				☐ Yes ☐ No	☐ Group ☐ Individual ☐ Dental ☐ Medical

If you need extra space, please request an additional form from your group administrator.

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Regence BlueCross BlueShield of Oregon and my employer and I agree to the terms and conditions of that master contract. I agree to abide by the Employer's enrollment provisions and certify that all those who I seek to enroll, including myself, meet the eligibility criteria as agreed to by the Group in the master contract. I understand that coverage cannot start until after I have served an eligibility waiting period agreed to by the employer as recorded on Regence BlueCross BlueShield of Oregon's records.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

If I have waived enrollment for myself or any of my dependents (including my spouse or eligible domestic partner) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express amendment signed by an officer of Regence BlueCross BlueShield of Oregon, no person, including, but not limited to any independent producer, agent, or employee of Regence BlueCross BlueShield of Oregon or of my employer, may change the terms of the master contract, any of its amendments, or this application and no person may waive the requirement that I answer all questions on this application completely and accurately. I understand that this application will become part of the contract between Regence BlueCross BlueShield of Oregon and my employer.

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 acting as agent for Regence BlueCross BlueShield of Oregon. 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 BlueCross BlueShield of Oregon, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence BlueCross BlueShield of Oregon may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed 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. Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand there may not be participating providers in all specialty areas.

I understand that a waiting period for coverage of preexisting conditions may apply. A preexisting condition waiting period may be reduced by any prior creditable health coverage I and/or my dependent(s) may have had, as long as there was not a significant lapse in coverage. I have the right to provide evidence of prior coverage. I can contact Regence BlueCross BlueShield of Oregon for assistance in obtaining proper evidence of prior coverage.

I have provided these answers as part of the application procedure required by Regence BlueCross BlueShield of Oregon to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueCross BlueShield of Oregon will rely on each answer in making coverage and rating determinations. For the protection of all members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BlueCross BlueShield of Oregon may result in Regence BlueCross BlueShield of Oregon taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence BlueCross BlueShield of Oregon in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature ________________________ Date ____________