Regence

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

Regence BlueShield of Idaho, Inc.
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax form to: 1-866-303-5117

Application for Enrollment/Change (for groups 101+)

Please print in black ink. Incomplete 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.

GROUP ADMINISTRATOR: This section should be completed by the Group Administrator.			
Group Number	Group Name		Requested Effective Date
10053941	**Kuna School District #3**		
Subgroup			Class
☐ Active ☐ COBRA ☐ Under 65 Retiree PERSI ☐ Under 65 Retiree Direct Bill			0001
Hours Per Week	Original Date of Hire	Full Time Date of Hire	Eligibility Waiting Period Start Date

SECTION 1 – NEW ENROLLMENT OR CHANGE

Employee Last Name	First Name		Middle Initial
Employee Mailing Address	City	State	ZIP
Employee Physical Address (same as mailing ☐)	City	State	ZIP
Primary Language / Daytime Phone Number	Email Address		

Marital Status: ☐ Single ☐ Married or Domestic Partnership registered by a U.S. or comparable governmental entity ☐ Divorced ☐ Non-Registered Domestic Partnership (must submit an Affidavit of Qualifying Domestic Partnership)

New Enrollment	**Special Enrollment**	**Changes**
Date of Event: _____	Date of Event: _____	☐ Name Change
☐ New Group/New Hire	☐ Birth/Adoption	New Name: _____
☐ Open Enrollment	☐ Loss of Coverage (complete Section 5)	Old Name: _____
☐ Rehire	☐ Marriage or Eligible Domestic Partnership	☐ Address Change (enter above)
	☐ Other _____	☐ Plan Selection

SECTION 2 – PLAN SELECTION

Refer to your Group Administrator for plan options available to you.

Medical

☐ Regence Classic $1,000 Deductible
☐ Regence HSA 3.0 $2,500 Individual / $5,000 Family Deductible

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SECTION 3 – ENROLLING MEMBERS

List all members for whom you are adding, changing or terminating Medical (M) benefits.

Add	Term	Benefit	Gender	Name (First, Middle, Last)	Social Security Number	Date of Birth	Relation
☐	☐	☐ M	☐ M ☐ F	**Employee/Subscriber**			**SELF**
☐	☐	☐ M	☐ M ☐ F				
☐	☐	☐ M	☐ M ☐ F				
☐	☐	☐ M	☐ M ☐ F				
☐	☐	☐ M	☐ M ☐ F				

This confirms that any employee or dependent for whom retroactive termination for administrative delay is requested had no expectation of coverage and paid no premium after the requested termination date.

Group Administrator Signature: _____ **Date:** _____

SECTION 4 – CURRENT AND PRIOR COVERAGE

Names of Covered Members	Health Insurance Carrier	Dates of Coverage	Coverage Continuing?	Coverage and Product Type
	Carrier Name: Policy Number: Carrier Phone:	Begin: End:	☐ Yes ☐ No	Coverage Type: ☐ Group ☐ Individual Product Type: ☐ Medical Medicare: ☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

Note: If coverage is provided for an enrolled child or children from a previous marriage or relationship, please attach a copy of any court documentation that shows who is responsible for the health care expenses or insurance of the child(ren) so that the carrier can determine which coverage should pay first.

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

SECTION 5 – APPLICANT SIGNATURE

I have reviewed and agree to the provisions set out in Section 7 – Acknowledgments and Authorizations below.

Applicant Signature _____ Date _____

SECTION 6 – 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 domestic partnership, 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.

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