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
Portland, Oregon 97201

Mail form to: PO Box 1271
Portland, OR 97207-1271

Fax to: 1-866-303-5117

Oregon Application for Enrollment/Change (for groups 1-50)

Please print in black 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	Class	Group Name	Requested Effective Date

Employee Last Name	First Name	Middle Initial

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:

☒ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date ____________

☐ Satisfaction of non-time-lapse based eligibility criteria-Date ____________

Members Current Employment Status:

☐ Actively working

☐ Retiree Retirement Start Date ____________

☐ COBRA Participant COBRA Start Date ____________

☐ Long Term Disability Long Term Disability Start Date ____________

CHANGE

Change:

☐ Add employee with/without dependent(s)

☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Change due to:

☐ Birth ☐ Marriage ☐ Adoption ☐ Open Enrollment ☐ COBRA Coverage Exhausted

☐ Loss of Eligibility on another plan* ☐ Court Order ☐ Add Eligible Domestic Partner

☐ Eligibility for group premium assistance under Medicaid or CHIP

☐ Loss of Medicaid or CHIP

*If enrolling due to loss of other coverage, include prior carrier information in Section 6.

Date of Change Event

Demographic Information Change:

☐ Name Change ☐ Address Change

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION (continued)

CANCELLATION AND/OR COBRA OR NON-COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)

☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)

☐ Cancel Dependent(s) - List: ____________________

Group Administrator signature is required below if cancellation is being requested with an effective date prior to the date this form will be received by Regence BlueCross BlueShield of Oregon.

COBRA or Non-COBRA Continuation Enrollment:

☐ COBRA

☐ Non-COBRA Continuation

If you are applying for COBRA or Oregon state continuation, mail this form to your employer. Do not mail to Regence.

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event:	**Date of Cancellation Event**
☐ Enrolled child no longer eligible ☐ Death ☐ Medicare Eligibility ☐ Military Leave ☐ Divorce, annulment, or termination of Domestic Partnership ☐ Reduction of Hours ☐ Termination of non-employment based membership in the covered group (e.g., union) ☐ Termination of Employment ☐ Other Medical Coverage ☐ Other reason________________	

This confirms that any employee and/or dependent for whom retroactive cancellation for administrative delay is requested on this form did not have an expectation of coverage after the requested cancellation effective date and did not pay premium for coverage beyond the requested cancellation effective date.

Group Administrator Signature ____________________ **Date** __________

SECTION 2 - PLAN SELECTION

Dental Plan Choices

☐ Dental ☒ No Dental

Medical Plan Choices

Refer to your Group Administrator for the appropriate plan choices and deductible options available to you.	☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ No Medical
Enter the deductible amount for the product selected.	Deductible ______________

* Under federal law, pediatric dental benefits must be maintained, however, Oregon prohibits the inclusion of pediatric dental benefits in these its standardized plans. Therefore, we cannot issue you a standardized plan without your assurance below that you have obtained coverage through a pediatric dental plan certified by Oregon Health Insurance Marketplace for myself and all individuals for whom I am making application.

☐ By this checkmark, I hereby provide assurance that I have obtained a pediatric dental plan certified by Oregon Health Insurance Marketplace for myself and all individuals for whom I am making applications.

Is this Plan an HSA?

If your employer is partnering with HealthEquity for your HSA bank account, it will be created for you automatically:

☐ Send my claims data to HealthEquity(optional) - I have read and agreed to the HSA authorization form.

OR

☐ No, I don't want a HealthEquity HSA.

SECTION 3 - EMPLOYEE INFORMATION

Physical Address	City, State, and ZIP Code
Mailing Address	City, State, and ZIP Code

Daytime Telephone Number ( )	E-mail Address	Primary Language
Date of Birth	Gender: ☐Female ☐Male	Social Security Number
Original Date of Hire	Full-time Date of Hire	Hours Per Week

Marital Status:

☐Single ☐Divorced ☐Non-Certified Domestic Partner

☐Married or Oregon-Certified Domestic Partner

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)

ELECTRONIC COMMUNICATIONS

Go paperless! Regence can send secure communications about your insurance claims and benefits to a regence.com account! Once registered, an email or text (your choice) will notify you when a new communication is posted.

Yes, please set up an account for me and email me a link to access and personalize it.
My email address: ______________________________

SECTION 4 - 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
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			

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

Application For Enrollment/Change (continued)

SECTION 5 - CHILD CUSTODY INFORMATION

If natural or adoptive parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the health care insurance of the dependent(s) so that the carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		

SECTION 6 - CURRENT AND PRIOR COVERAGE

Name of Covered Members and Policy Information	Will Coverage Continue?	Product and Coverage Type
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐Yes ☐No	**Coverage Type:** ☐Group ☐Individual **Product Type:** ☐Medical ☐Dental **Medicare:** ☐PartA ☐PartB ☐PartD
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐Yes ☐No	**Coverage Type:** ☐Group ☐Individual **Product Type:** ☐Medical ☐Dental **Medicare:** ☐PartA ☐PartB ☐PartD
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐Yes ☐No	**Coverage Type:** ☐Group ☐Individual **Product Type:** ☐Medical ☐Dental **Medicare:** ☐PartA ☐PartB ☐PartD

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

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

SECTION 7 - APPLICANT SIGNATURE

I understand that, when, by law, this coverage would not be primary to Medicare Part B had I or any of my dependents properly enrolled in Medicare Part B when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by Medicare Part B, regardless of whether or not I or my dependent choose to accept those Medicare benefits. In addition, if I or any of my dependents is eligible for Medicare, Regence will not pay me or my dependent or my or his or her Provider for any part of expenses incurred if the Provider has opted out of Medicare participation.

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 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'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 eligible spouse or 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 or 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 domestic partnership, 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, no person, including, but not limited to any independent producer, agent, or employee of Regence 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 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. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

SECTION 8 - APPLICANT SIGNATURE (continued)

I authorize any source to release to Regence, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence 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 have provided these answers as part of the application procedure required by Regence to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence 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 may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage and/or denial of benefits, and/or could subject me to prosecution for insurance fraud.

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 in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Important: Signature and Date required to avoid delays in processing your application.

Applicant's Signature ▶ ______________________________ Date ________________