Regence

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

Regence BlueCross BlueShield of Oregon
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax to: 1-866-303-5117
Email to: Regence_Membership@regence.com

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

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	Subgroup	Class	Group Name	Requested Effective Date

Hours Per Week	Original Date of Hire	Full Time Date of Hire	Eligibility Waiting Period Start Date

SECTION 1 – NEW ENROLLMENT, CHANGE OR TERMINATION

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 ☐ Divorced ☐ Married/Registered Domestic Partnership ☐ Non-Registered Domestic Partnership (must submit an Affidavit of Qualifying Domestic Partnership)

New Enrollment/Termination

Date of Event: _____

- ☐ New Group/New Hire
- ☐ Open Enrollment
- ☐ Rehire
- ☐ Termination

Special Enrollment

Date of Event: _____

- ☐ Birth/Adoption
- ☐ Loss of Coverage (complete Section 5)
- ☐ Marriage/Eligible Domestic Partnership
- ☐ Other _____

Changes

- ☐ Name Change
  - New Name: _____
  - Old Name: _____
- ☐ Address Change (enter above)
- ☐ Plan Selection

SECTION 2 – PLAN SELECTION

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

Dental	**Medical**
☐ Dental ☐ No Dental	Select metal level: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ No Medical
	Select your network: ☐ Preferred ☐ Legacy LHP
	Enter your deductible amount: $_____

HSA (health savings account) health plans only: If your employer has partnered with HealthEquity for your HSA bank account, it will be created for you automatically. No further action is required from you; however, you have the following alternative options:

☐ Send my claims data to HealthEquity. I have read and agreed to the *HSA Authorization Form*.

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

SECTION 2 – PLAN SELECTION (continued)

Standardized Plans Only: Federal law requires you to have pediatric dental benefits (for any person under age 19), but Oregon law forbids them in standardized plans. We cannot issue you a standardized plan without assurance below that you and all those for whom you are applying have or will have an Exchange-certified pediatric dental plan.

☐ By checking this box, I provide my assurance that I have pediatric dental plan coverage of the type, and for all persons, described above.

SECTION 3 – ENROLLING MEMBERS

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

Add	Term	Benefit	Gender	Name (First,Middle,Last)	Social Security Number	Date of Birth	Relation
☐	☐	☐ M ☐ D	☐ M ☐ F	**Employee/Subscriber**			**SELF**
☐	☐	☐ M ☐ D	☐ M ☐ F				
☐	☐	☐ M ☐ D	☐ M ☐ F				
☐	☐	☐ M ☐ D	☐ M ☐ F				
☐	☐	☐ M ☐ D	☐ 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 – COBRA OR NON-COBRA CONTINUATION ENROLLMENT

You or your dependents may be entitled to COBRA or Non-COBRA continuation due to loss of current coverage. Select an option for continuing coverage below, or select "None" if not electing.

Reasons for entitlement include loss of coverage due to: Termination of employment; Enrolled child no longer eligible; Medicare entitlement; Reduction of hours; Divorce/termination of Domestic Partnership; Death.

Type of Continuation: ☐ COBRA ☐ Non-COBRA Continuation ☐ None

Reason for Entitlement: _____ Date of Event: _____

SECTION 5 – 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 ☐ Dental 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 6 – APPLICANT SIGNATURE

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

Applicant Signature: _____ Date: _____

SECTION 7 – 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, 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 dependent(s) within 30 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 contracted 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. For the protection of all members, fraud or misrepresentation of material fact by me for the purpose of defrauding Regence may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage or denial of benefits, or could subject me to prosecution for insurance fraud.

Regence BlueCross BlueShield of Oregon: 100 SW Market Street, Portland, OR 97201