Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Washington
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

# Application For Enrollment/Change (101+)

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 boxes with * directly below should be completed by the Group.

## SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

| Group Number* | Subgroup* | Class* | Group Name* | Requested Effective Date* |
|---|---|---|---|---|
| 1 0 0 0 0 5 7 0 | | | BURLINGTON EDISON SCHOOL DISTRICT | |

| Employee Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Full Time Date of Hire* | Original Date of Hire* | Hours Per week* | Eligibility Waiting Period Start Date* |
|---|---|---|---|
| | | | |

| Employee Mailing Address | City, State, and ZIP Code | Primary Language |
|---|---|---|
| | | |

Daytime Telephone Number ( )

**Marital Status:** ☐Single ☐Divorced ☐Married/Registered Domestic Partner ☐Non-Registered Domestic Partner**

** Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.

**New Enrollment / Termination**
Date of Event:_____
☐ New Group/New Hire
☐ Open Enrollment
☐ Rehire
☐ Termination****

**Special Enrollment**
Date of Event:_____
☐ Marriage/Eligible Domestic Partner
☐ Birth/Adoption
☐ Loss of other coverage***
☐ Other_____

**Changes**
☐ Name Change
New Name: _____
Old Name: _____
☐ Address change - enter in section 3
☐ Plan Selection

*** For loss of other coverage, prior coverage information must be included on page 2.

**** For COBRA/Non-COBRA Continuation Enrollments, see section 5.

## SECTION 2 - PLAN SELECTION

**Medical:** ☐HSA 2.0 1500 ☐Innova 2500 ☐Engage 70 ☐Innova A ☐Innova B ☐Innova 750

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 - ENROLLING MEMBERS - List Members you are Adding Removing or Changing

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

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

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



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## SECTION 4 - GO PAPERLESS

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 e-mail address is _____

## SECTION 5 - COBRA OR NON-COBRA CONTINUATION ENROLLMENT

COBRA /Non-COBRA Continuation ☐ COBRA ☐ Non-COBRA Continuation

Reason for Entitlement** _____ Date of Event: _____

**Reasons include: Enrolled child no longer eligible, Medicare Entitlement, Reduction of Hours, Divorce/Termination of Domestic Partnership, Death, Termination of Employment.

## SECTION 6 - CURRENT AND PRIOR COVERAGE

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

| Other Carrier Name, Policy Number, Phone Number | |
|---|---|
| Policy Holder Name | Names of Covered Members |

| Types of Coverage (check all that apply) | Coverage Start Date *mm/dd/yyyy* | Is this coverage terminating? | Coverage End Date *mm/dd/yyyy* |
|---|---|---|---|
| ☐ Group ☐ Individual<br>☐ Medical ☐ Dental<br>☐ Medicare ☐ Part A ☐ Part B ☐ Part D | | ☐ Yes<br>☐ No | |

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

## SECTION 7 - APPLICANT SIGNATURE

I certify that all information provided on this form is true, correct and complete. In addition, have reviewed and agree to the provisions set out in the Acknowledgments and Authorizations section below.

Applicant's Signature _____ Date _____

## SECTION 8 - ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or cancellation 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 anniversary 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 and or new dependents within 30 days of marriage or domestic partnership, or within 60 days of birth, adoption, or placement for adoption (if additional premium is due and paid for the child). Please call 1 (866) 228-7139 for more information about these rules.

I understand Regence will rely on all information provided on this form in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance and/or benefits.

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, and/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.