State of Idaho
Medical Enrollment Application

Blue Cross of Idaho

If you have questions, call:
Department of Administration
Office of Group Insurance
650 W. State St., Suite 100
Boise, ID 83720-0035
208-332-1860 or 1-800-531-0597
ogi.idaho.gov

POLICY TYPE (please check one):

- ❑ **High Deductible**
- ❑ **PPO**
- ❑ **Traditional**

Date of Application: _____

Effective Date *(subject to BCI approval)*: _____

Group Number: 10040000

Please complete *each* section on the front and back page of this application in ink.

Applicant Information (Employee)

Your Name *(first, initial, last)*	Blue Cross ID Number *(if currently enrolled)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	☐ Male ☐ Female
		/ /	/ /	

Mailing Address	City, State, Zip Code	Email Address *(for official communications)*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Hire Date	Phone Number	Department or agency with which you are employed:
		( )	Boise State University

COMPLETE ONLY TO DECLINE ALL BENEFITS *(Do not complete the information below this box.)* I hereby decline **all** benefits. I understand that benefits may be added during open enrollment or following a qualifying life event, as outlined in the State of Idaho member contract.

Signature: _____ **Date:** _____

Coverage options: You may enroll for medical or dental or both. Employee must be enrolled in the coverage to enroll dependents.

Medical Enrollment *(includes vision, prescription drug and EAP)*

- ☐ Self only
- ☐ Self and spouse
- ☐ Self, spouse and 1 child
- ☐ Self, spouse and 2+ children
- ☐ Self and 1 child
- ☐ Self and 2+ children
- ☐ Decline

Employment Type

- ☐ Full-time employee
- ☐ Part-time employee

Health Savings Account

If enrolling in the HDHP, will you also enroll in the State of Idaho-sponsored Health Savings Account? ☐ Yes ☐ No

Dental Enrollment

- ☐ Self only
- ☐ Self and spouse
- ☐ Self, spouse and 1 child
- ☐ Self, spouse and 2+ children
- ☐ Decline
- ☐ Self and 1 child
- ☐ Self and 2+ children

Enrollment/Benefit Change Request

1. Are you transferring to a new state department or agency? ☐ Yes ☐ No Transfer date: _____
   Transferring to: _____
   Transferring from: _____
2. Are you: ☐ A new hire ☐ Enrolling during open enrollment ☐ Adding self and/or dependents outside of open enrollment ☐ Removing dependents
3. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) _____ *(documentation may be required)* ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Death
   ☐ Involuntary loss of ***employer*** coverage* ☐ Involuntary loss of ***individual*** coverage *Provide name of carrier _____
   ☐ Involuntary loss of Medicaid ☐ Court order *(copy of court order required)* ☐ Other _____

Spouse & Eligible Children to be Enrolled *(list everyone you wish to enroll, disenroll, or keep on the plan with no changes)*

Dependent's Name (first, initial, last)	**Relationship (spouse, child, stepchild, etc.)**	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**	**Gender**	**Medical Coverage Updates**	**Dental Coverage Updates**
Dependent 1				☐ Male ☐ Female	☐ Enroll ☐ Disenroll ☐ No changes	☐ Enroll ☐ Disenroll ☐ No changes
Dependent 2				☐ Male ☐ Female	☐ Enroll ☐ Disenroll ☐ No changes	☐ Enroll ☐ Disenroll ☐ No changes
Dependent 3				☐ Male ☐ Female	☐ Enroll ☐ Disenroll ☐ No changes	☐ Enroll ☐ Disenroll ☐ No changes
Dependent 4				☐ Male ☐ Female	☐ Enroll ☐ Disenroll ☐ No changes	☐ Enroll ☐ Disenroll ☐ No changes
Dependent 5				☐ Male ☐ Female	☐ Enroll ☐ Disenroll ☐ No changes	☐ Enroll ☐ Disenroll ☐ No changes

Is spouse an employee of an agency that participates in the State of Idaho Health Plan? ☐ YES ☐ NO If YES, spouse's name: _____

Social Security Number: _____ **Department/Agency:** _____

Spouse must complete a separate application to enroll or to decline coverage. Participants cannot be actively enrolled more than once on the State of Idaho Health Plan.

FOR OFFICE USE ONLY

OVER ☛

Original applications must be submitted to your AGENCY HUMAN RESOURCES OFFICE

Form No. 3-700 (03-23)

Auditor _____

Current/Prior Coverage Information *(Please complete for proper coordination of benefits administration.)*

Is any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy? ❑ Yes ❑ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Start Date of Policy (mm/dd/yy)	Will Current Policy Continue?[2]
Employee					☐ Yes ☐ No
Spouse					☐ Yes ☐ No
Child					☐ Yes ☐ No
Child					☐ Yes ☐ No
Child					☐ Yes ☐ No

If any person listed on this application is covered by Medicare, please complete the following:

_____ Name

_____ Medicare Beneficiary Number

_____ Reason for Medicare Entitlement (age, disability of ESRD)

Date of Medicare Entitlement: Part A _____ (mm dd yy) Part B _____ (mm dd yy)

[2] If your current coverage will remain active, please indicate if coverage is for: ☐ Medical ☐ Dental ☐ Vision

[2] If your current coverage will be terminated, please indicate termination date: _____ (mm dd yy)

Disability Information

Total disability is a condition resulting from disease or accidental injury, as certified in writing by an attending physician, that renders the enrollee/member incapable of performing the principal duties of regular employment/occupation for which he/she is qualified/trained and he/she is not engaged in any work, profession or avocation for fees, gain or profit; or he/she is unable to engage in the normal activities of an individual of the same age and gender.

Are you or any of your dependents currently *totally* disabled? ☐ YES ☐ NO *(If YES, complete information below.)*

_____
Nature of Total Disability

_____ _____ _____
Name of Totally Disabled Person *Physician's Name* *Physician's Phone Number*

_____ _____
Date of Total Disability *Physician's Address*

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage 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. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***bcidaho.com***.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.
- I have read and understand the group health plan dependent eligibility requirements and further understand that I am required at the time a dependent loses eligibility to submit an application removing the ineligible dependent from coverage within thirty (30) days. I further understand and agree that failure to do so may result in recovery of benefits to the extent allowable by law.

APPLICATION MUST BE SIGNED AND DATED

Signature_____

Date_____