



# State of Idaho Medical Enrollment Application



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](http://ogi.idaho.gov)

<b>POLICY TYPE (please check one):</b>
<input type="checkbox"/> High Deductible
<input type="checkbox"/> PPO
<input type="checkbox"/> 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)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address	City, State, Zip Code	Email Address (for official communications)		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Hire Date	Phone Number ( )	Department or agency with which you are employed:	

**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: \_\_\_\_\_

Type of Enrollment	Employment Type	Dental Enrollment
<b>MEDICAL (includes vision, prescription drug and EAP benefits)</b> <input type="checkbox"/> Self only <input type="checkbox"/> Self and 1 child <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self and 2+ children <input type="checkbox"/> Self, spouse and 1 child <input type="checkbox"/> Self, spouse and 2+ children	<input type="checkbox"/> Full-time employee <input type="checkbox"/> Part-time employee	<input type="checkbox"/> Self only (required) <input type="checkbox"/> Self and dependents <b>Dental coverage is required for the subscriber. If you decline coverage for dependents, they may only be added to your policy during open enrollment or following a qualifying life event.</b>

Enrollment/Benefit Change Request
1. Are you transferring to a new state department or agency? <input type="checkbox"/> Yes <input type="checkbox"/> No Transfer date: _____ Transferring to: _____ 2. Are you: <input type="checkbox"/> A new hire <input type="checkbox"/> Enrolling during open enrollment <input type="checkbox"/> Adding self and/or dependents outside of open enrollment <input type="checkbox"/> Removing dependents 3. If you are enrolling <b>outside</b> 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) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Involuntary loss of <b>employer</b> coverage* <input type="checkbox"/> Involuntary loss of <b>individual</b> coverage *Provide name of carrier _____ <input type="checkbox"/> Involuntary loss of Medicaid <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____

Spouse & Eligible Children to be Enrolled (list all family members you wish to enroll and disenroll)					
Dependent's Name (first, initial, last)	Relationship (spouse, child, stepchild, etc.)	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	
Dependent 1				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll
Dependent 2				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll
Dependent 3				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll
Dependent 4				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll
Dependent 5				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll

Is spouse a State of Idaho employee?  YES  NO If YES, spouse's name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Department: \_\_\_\_\_

\*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

**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? <sup>2</sup>
Employee					<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> 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                Part B                 
mm dd yy mm dd yy

<sup>2</sup> If your current coverage will remain active, please indicate if coverage is for:  Medical  Dental  Vision

<sup>2</sup> 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](http://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 \_\_\_\_\_