



Regence

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

Regence BlueCross BlueShield of Oregon

EMPLOYEE ENROLLMENT FORM

Employer Name _____

New Enrollment - Date of Full-Time Hire/Rehire (mm/dd/yyyy) _____

Change of Existing Enrollment

FOR EMPLOYER USE ONLY:

Group No. _____

Package No. _____

Requested Effective Date _____

FOR PLAN USE ONLY:

Alternate ID Number _____

Please complete all information on this form:

Employee's Last Name	Employee's First Name	Middle Initial	e-mail address	Social Security No.	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address & Apt. No./Mailing Address			City	State	ZIP Code	Home Phone () Business Phone ()
<input type="checkbox"/> Married or Oregon-Certified Domestic Partner (DP) <input type="checkbox"/> Non-Certified DP <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed						

Dependents to be enrolled:

Plan Use	Full Last Name	Full First Name	Middle Initial	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender M/F	Relationship to Employee	Enrolling in:
Employee 1	Same as Above	Same as Above	Same	Same as Above	Same as Above	Same	Self	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Spouse/DP 2					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 3					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 4					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 5					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 6					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Child 7					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental

Has any person listed on this application used tobacco during the past 12 months; if yes, list applicant's name (not applicable to Washington based groups):

If changing existing enrollment, indicate reason below:

<input type="checkbox"/> Name Change - Former name _____	<input type="checkbox"/> Add Dependent due to: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage - Date _____ <input type="checkbox"/> OR Certified DP - Date _____ <input type="checkbox"/> Non-Certified DP (Affidavit of Domestic Partnership required)	<input type="checkbox"/> Newborn <input type="checkbox"/> Loss of Coverage - Date _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Delete Dependent - Reason _____ Name(s) _____ If applicable - Final date of divorce, annulment or termination of domestic partnership _____
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List any of the above dependent(s) attending a boarding school, accredited college or university. Include the name and location of the school.

Your plan may have a preexisting exclusion period. A preexisting period must be reduced by any prior creditable health coverage you and/or your dependent(s) may have had as long as there was not a lapse in coverage of 63 days in Oregon or 90 days in Washington. You have the right to provide evidence of prior coverage. Refer to your benefits booklet for details or check with your employee benefits administrator.

Please Complete and Sign the Reverse Side

In the columns below (A, B, C and D), please check applicable medical and dental choices based on the plan(s) your employer has purchased.

A) Medical Choice: <input type="checkbox"/> BlueEssentials SM	B) Deductible Choice: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000	C) Network Choice: <input type="checkbox"/> Participating	D) Dental Choice: <input type="checkbox"/> Fee-for-Service (choose any licensed dentist)
<input type="checkbox"/> BluePreferred [®] * Groups of 51 plus	<input type="checkbox"/> \$250* <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$3000	<input type="checkbox"/> Preferred Provider Plan	<input type="checkbox"/> Dentacare Available for groups of 100 plus only (Willamette Dental Group- requires services only at Willamette Dental Group offices)
<input type="checkbox"/> BlueClassic SM * Groups of 51 plus	<input type="checkbox"/> \$250* <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000	<input type="checkbox"/> Access	
<input type="checkbox"/> Regence HSA Healthplan/Regence HSA Qualified Plan* *Regence HSA Qualified Plan (available only for employees of groups that currently have this plan)	<input type="checkbox"/> \$1500 single/\$3000 family * <input type="checkbox"/> \$3000 single/\$5000 family ** <input type="checkbox"/> \$2500 single/\$5000 family * <input type="checkbox"/> \$3000 single/\$7000 family ** <input type="checkbox"/> \$3500 single/\$7000 family * <small>* Family consists of more than one member. Entire family deductible must be met before benefits begin for any family member. ** These deductible choices do not apply to Regence HSA Qualified Plan. Benefits begin for a member once \$3000 amount is met or once the family deductible is met, whichever occurs first.</small>	<input type="checkbox"/> Participating Network <input type="checkbox"/> Preferred Provider Plan	<input type="checkbox"/> Basic Oregon Plan Dental <input type="checkbox"/> Dental not applicable
<input type="checkbox"/> Basic Oregon Plan - Traditional	Deductible not applicable	Participating Network	
<input type="checkbox"/> Other Medical Plan _____	Deductible _____	Network _____	
<input type="checkbox"/> Medical Plan not applicable	Not applicable	Not applicable	

CURRENT/PRIOR COVERAGE INFORMATION (This is not a waiver of coverage. This information is required for payment of claims.)

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE.

MEDICARE If you or any family members listed on this application have Medicare, is coverage? Part A Part B Part D, and please complete the following information:

Enrolling Individual	Effective Date	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement		
Enrolling Individual	Effective Date	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement		
Applicant's Name (Non-Medicare)	Insurance Carrier (Policy Number and Phone Number)	Date of Coverage Month/Day/Year	Will coverage continue?	Type of Coverage	
		From	To	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

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. **

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). A separate authorization will be required for psychotherapy notes.

For the protection of all of our members, fraud or misrepresentation of material fact by me and/or the group for the purposes of defrauding Regence BlueCross BlueShield of Oregon may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

** For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available by telephone request or on our Web site at www.or.regence.com.

Employee's Signature

Date

Employee's Full Name (please print clearly)