Regence

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

Regence BlueCross BlueShield of Utah
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Portland, OR 97207-1271
Fax to: 1-866-303-5117

Utah Small Employer Application Cover Sheet for groups 2-50
(to be used with the Utah Small Employer Health Insurance Application)

New/Renewed Groups - This form applies to new groups and groups that have renewed their benefits on Metallic (platinum, gold, silver and bronze) plans.

Please print in black ink only.

SECTION 1 - GENERAL INFORMATION (to be completed by the Group Administrator)

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date
				(mm/dd/yyyy)
Employee Last Name			First Name	Middle Initial

SECTION 2 - NEW ENROLLMENT

New Enrollment due to:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date _____ (mm/dd/yyyy)

☐ Satisfaction of non-time-lapse based eligibility criteria _____ (mm/dd/yyyy)

Current employment status:

☐ Actively working ☐ Retiree ☐ COBRA Participant ☐ Disability ☐ Other _____

SECTION 3 - PLAN SELECTION

Medical Plan Choices		Pharmacy	Additional Benefits
☐ BluePoint Platinum $500	☐ BluePoint Silver $2,000	Embedded with Medical Plan	☐ Adult Dental
☐ BluePoint Gold $500	☐ BluePoint Silver HSA $2,000		☐ Employee Asst Program (EAP)
☐ BluePoint Gold+ $1,000	☐ BluePoint Silver HSA 100%		☐ Adult Vision
☐ BluePoint Gold $1,500	☐ BluePoint Silver Simple		☐ Unlimited Spinal Manipulation
☐ BluePoint Gold HSA $1,400	☐ BluePoint Bronze+ $3,000		
☐ BluePoint Gold Simple	☐ BluePoint Bronze HSA+ $2,750		
☐ BluePoint Silver+ $1,750	☐ BluePoint Bronze HSA $5,000		

If your medical plan allows network selection, please select a network.

Network: ☐ Preferred FocalPoint ☐ Preferred ValueCare ☐ Participating

☐ **Health Savings Account:** I have elected Regence HSA Healthplan coverage but do not wish to enroll in an integrated HSA with our HSA banking partner.

If you are opting to include a HSA savings account in this Cover Sheet, you will need to provide your Social Security Number in Section C of the Utah Small Employer Employee Health Insurance Application.

Note: Your medical plan may contain a waiting period for transplants during which no coverage of transplants is provided. However, any such waiting period may be reduced or eliminated by your combined periods of creditable coverage. Please attach a copy of any Certificate(s) of Creditable Coverage from your or any family member's current or prior coverage if applicable.

DENTAL: ☐ Encore ☐ Radiance ☐ Expressions ☐ Expressions Value Care ☐ No Dental

Complete Waiver of Coverage section if waiving coverage.

SECTION 4 - CANCELLATION REASON/COBRA OR MINI-COBRA CONTINUATION QUALIFYING EVENT:

Complete this section if requesting cancellation and/or continuation of coverage.

Cancellation: (select cancellation reason and enter cancellation date below)

☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)

☐ Cancel Dependent(s) - List: _____

Group Administrator signature is required below if cancellation is being requested with an effective date prior to the date this form will be received by Regence BlueCross BlueShield of Utah.

COBRA or Mini-COBRA Continuation Enrollment: (Complete sections A, B, and C on the Utah Small Employer Health Insurance Application.)

☐ COBRA ☐ Utah mini-COBRA/State Continuation

Cancellation Reason/COBRA or Mini-COBRA Continuation Qualifying Event:	**Date of Cancellation Event**
☐ Dependent child no longer eligible ☐ Death ☐ Medicare Entitlement ☐ Military Leave ☐ Divorce, annulment, or termination of Domestic Partnership ☐ Reduction of Hours ☐ Termination of Employment ☐ Other Medical Coverage ☐ Other reason _____	(mm/dd/yyyy)

This confirms that any employee and/or dependent for whom retroactive cancellation for administrative delay is requested on this form did not have an expectation of coverage after the requested cancellation effective date and did not pay premium for coverage beyond the requested cancellation effective date.

Group Administrator Signature ▶ _____ **Date** (mm/dd/yyyy) _____

SECTION 5 – CURRENT/PRIOR COVERAGE INFORMATION

MEDICARE: If you or any family members listed on this application have Medicare, please complete the following information:

Enrolling Individual	Effective Date (mm/dd/yyyy)	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply)
			☐ Part A ☐ Part B ☐ Part D
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD			
Enrolling Individual	Effective Date (mm/dd/yyyy)	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply)
			☐ Part A ☐ Part B ☐ Part D
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD			

SECTION 6 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence BlueCross BlueShield of Utah (Regence) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on Regence.com. An e-mail notice is sent to a member-supplied e-mail account when a new communication is posted on Regence.com.

By my electronic signature below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish Regence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but I agree that my consent will apply to the following materials available, or as they become available, for electronic distribution: (i) notices of enrollment and/or effective date of coverage, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a communication can be distributed electronically, a paper copy will be provided.
- Once available, any electronically distributed communications may be printed from the Regence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using Regence.com or by contacting Customer Service at the number provided on my member card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using Regence.com or by contacting Customer Service. I understand it may take up to three working days to update Regence.com with this change.

The e-mail address for receipt of notice of electronic distributions is Email address _____

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Applicant's Signature ▶ _____ Date (mm/dd/yyyy) _____

Any accompanying foreign language version of this form is provided only as an accommodation or courtesy to the customer and this English language version shall control the resolution of any dispute or complaint.

UTAH SMALL EMPLOYER
EMPLOYEE HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)

☐ New Group	☐ Newborn	☐ Loss of Coverage_____
☐ Open Enrollment	☐ Court Order	☐ Marriage_____
☐ New Hire	☐ Dependent Addition	☐ Divorce_____
☐ New Application	☐ Other:_____	☐ Military Leave of Absence(USERRA)_____
☐ COBRA	☐ Utah mini-COBRA	

Length of continuation coverage: ☐ 12 mos. ☐ 18 mos. ☐ 36 mos. ☐ Other:

Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

☐ WAIVER OF COVERAGE Individuals waiving coverage complete Waiver of Coverage.

A. EMPLOYER INFORMATION

Employer _____ Is this a division? ☐ Yes ☐ No If "Yes," name of parent company _____

B. EMPLOYEE INFORMATION

Name (Last) _____ (First) _____ (MI) _____ Job Title _____ Hrs/Week _____

Employment status ☐ Full-time ☐ Owner/business partner ☐ Retired ☐ Other _____ Hire Date _____ Rehire Date _____

Marital Status ☐ Legally Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner*

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home/Cell Phone (____) _____ Business Phone (____) _____ Email Address: _____

If you are American Indian or Alaska Native, provide the state and name of your federally-recognized tribe: _____

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all dependents applying for coverage. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use:
Employee				☐ Male ☐ Female	☐ Yes ☐ No
Spouse/ Domestic Partner*				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No

*Check with your employer to determine if domestic partner coverage is available.

D. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, Medicaid, or Medicare currently in effect. This will be used to determine if benefits will be coordinated. Each person applying for coverage must be listed below. If no health care coverage is in effect, indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	Date of Coverage MM/YY End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Employee:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Spouse/Domestic Partner:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____

E. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after the waiting period. I authorize my employer to act as my agent in all matters of administration of the group program.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible dependents.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, correct and complete. I acknowledge that if any information provided is false, the insurer may without advance notice pursue any remedies available under state or federal law, including declaring the coverage null and void and canceling the coverage retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms.

Employer: _____

Employee Name: (Last) _____ (First)_____ (MI) _____

Employee Signature_____Date_____

WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employee Name: (Last) _____ (First)_____ (MI) _____

Employer: _____

INDIVIDUALS WAIVING COVERAGE

Name of individual waiving coverage	Reason for waiving coverage	Insurer (Including policyholder name, insurer name and phone number)	Will coverage continue?
Employee:	☐ Other employer group coverage ☐ Individual coverage ☐ Governmental (Medicare, Medicaid, Tricare, etc.) ☐ Other_____		☐ Yes ☐ No
Spouse / Domestic Partner:			
Dependent:			
Dependent:			
Dependent:			

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse/domestic partner) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this Waiver of Coverage form is true, correct and complete.

Employee Signature_____Date_____