Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
Salt Lake City, UT 84130-0270
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

Application For Enrollment/Change/Waiver (for groups 100+ self-insured)

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 five boxes directly below should 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

NOTICE: WAIVER OF COVERAGE Individuals waiving coverage complete only Section 9

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

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)

Subscribers Current Employment Status:
☐ Actively working
☐ Retiree Retirement Start Date (mm/dd/yyyy)
☐ COBRA Participant COBRA Start Date (mm/dd/yyyy)
☐ Long Term Disability Long Term Disability Start Date (mm/dd/yyyy)

CHANGE

Change:
☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Change due to:
☐ Birth ☐ Marriage ☐ Adoption ☐ Open Enrollment ☐ COBRA Coverage Exhausted
☐ Loss of Eligibility on another plan ☐ Court Order
☐ Add Eligible Domestic Partner ☐ Loss of Medicaid or CHIP
☐ Eligibility for group premium assistance under Medicaid or CHIP

Date of Change Event
(mm/dd/yyyy)

Demographic Information Change:
☐ Name Change ☐ Address Change

CANCELLATION AND/OR COBRA ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)
☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)
☐ Cancel Dependent(s) - List: _____

☐ COBRA Enrollment

Cancellation Reason/COBRA Qualifying 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 _____

Date of Cancellation Event
(mm/dd/yyyy)

F5283.XUT0EN01150106

SECTION 2 - PLAN SELECTION

MEDICAL: ☐ BluePoint ☐ Regence HSA Healthplan 2.0 ☐ Regence HSA Healthplan 3.0 ☐ Regence Preferred ☐ Innova ☐ Engage ☐ No Medical

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

Network: ☐ Preferred FocalPoint ☐ Preferred BlueOption ☐ 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 HSA savings account in this application, you will need to provide your Social Security Number in Sections 3 and 4 of this application.

NOTE: Your medical plan may contain a 12-month 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 ☐ No Dental

VISION: ☐ Vision Service Plan

SECTION 3 - EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Mailing Address	City, State, and ZIP Code

Physical Address	City, State, and ZIP Code

Daytime Telephone Number (xxx) xxx-xxxx	E-mail Address Email address	Primary Language

Date of Birth (mm/dd/yyyy)	Gender: ☐ Female ☐ Male	Social Security Number	Original Date of Hire (mm/dd/yyyy)

Full-time Date of Hire (mm/dd/yyyy)	Hours Per Week	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Domestic Partner

What type of member card would you like to receive?

☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

SECTION 4 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number for each Individual Covered	Birthdate Mo/Day/Yr
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			

If you need extra space, please request an additional form from your group administrator.

SECTION 5 - CHILD CUSTODY INFORMATION

If natural parents are separated or divorced, please indicate below who has legal custody of the child(ren). Please use additional paper if needed. 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 health care insurance of the dependent(s) so that the carrier can determine whose coverage is primary.

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)?
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	
	☐	☐	☐	☐	(mm/dd/yyyy)	

SECTION 6 - CURRENT AND PRIOR COVERAGE

Name of Covered Members: Self and Dependent(s)	Insurance Company (Name, Phone Number, and Policy Number)	Date of Coverage	Will coverage continue while on this Plan?	Product and Coverage Type
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD
	Name: Phone: (xxx) xxx-xxxx Policy Number:	To: (mm/dd/yyyy) From: (mm/dd/yyyy)	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ PartA ☐ PartB ☐ PartD

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

SECTION 7 - STATEMENT OF ELECTRONIC DELIVERY AND RIGHT TO WITHDRAW CONSENT

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) acknowledgments 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 acknowledgments 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) _____

SECTION 8 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the self-insured plan maintained by my employer (for which Regence provides claims administration services, but does not assume financial risk or obligation) and I agree to the terms and conditions of that plan. I agree to abide by the plan's enrollment provisions and certify that all those whom I seek to enroll, including myself, meet the plan's eligibility criteria. I understand that coverage cannot start until after I have served any eligibility waiting period included in the plan.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

SECTION 8 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my eligible spouse or domestic partner) because of other health insurance or group health plan coverage, I may in the future 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. I may also enroll waived individuals within 30 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, if I have a new dependent as a result of marriage or domestic partnership, 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 or domestic partnership, or within 60 days after the birth, adoption, or placement. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express and duly authorized amendment to the plan, no person may change the terms of the plan. No person may waive the requirement that I answer all questions on this application completely and accurately.

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 acting as 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 about me or my dependents (persons who are eligible for benefits coverage and are listed 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). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand there may not be participating providers in all specialty areas.

I have provided these answers as part of the application procedure for the plan and I certify that all information completed on this form is true, correct, and complete. I understand that the plan will rely on each answer in making coverage and rating determinations. For the protection of all enrollees, fraud or misrepresentation of material fact by me for the purposes of defrauding the plan may result in the plan 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.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform the plan in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

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.

SECTION 9 - WAIVING COVERAGE

EMPLOYEE INFORMATION

Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)

Date of Hire (mm/dd/yyyy)	Average number of hours worked per week	Waiving coverage for:
		☐ Employee ☐ Employee/Dependent(s) ☐ Dependent(s) Only

I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Utah (Regence), but I am waiving coverage for the following reason(s). **Check all that apply:**

☐ I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.

☐ I currently have medical coverage elsewhere:

Carrier _____ **Policy Number** _____

Member ID Number _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

☐ I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time.

☐ I currently have dental coverage elsewhere:

Carrier _____ **Policy Number** _____

Member ID Number _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier, Policy Number or Member ID Number, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits).

Name of Individual Waiving Coverage	Carrier	Policy Number	Member ID Number

HEALTH INFORMATION

Is any applicant pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? ☐ Yes ☐ No

If currently pregnant, provide expected due date _____ (mm/dd/yyyy)

Do you anticipate complications or multiple births? ☐ Yes ☐ No

Have you had prior complications or multiple births? ☐ Yes ☐ No

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage or an employer stops contributing towards other group coverage, provided that you request enrollment within 30 days after you or your dependent's other coverage ends or employer contributions stop. You may also enroll waived individuals within 30 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, if you waive enrollment under this medical/dental plan at this time, and later acquire a new dependent due to marriage or domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage or domestic partnership, or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through the plan until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I have provided these answers as part of the application process for the plan required by the Issuer to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the plan will rely on each answer in making coverage and rating determinations. For protection of all members, knowingly providing false, incomplete, or misleading information for the purposes of defrauding the plan may result in the plan 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.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

▶ _____ (mm/dd/yyyy) _____

Signature of Employee | Date