

Statewide Schools ASC Health/Dental/Vision **Enrollment Application**

Requested Effective Date (subjec	to Blue Cross of Idaho approval)	_
Group Number <u>10036146</u>		
□ PPO Medical	□ HSA Blue SM PPO	
☐ Traditional Medical	☐ HSA Blue SM POS	
☐ Managed Care Medical POS	☐ Traditional Dental	
□ PPO Dental	☐ Dental Blue Connect	
	☐ Vision	

Please complete each	section of the	nis applicat	ion in i	nk.								
Applicant Infor	<mark>mation</mark> (Er	nployee)										Les CAUS
Your Name (first, initial, last)						Cross ID No. rrently enrolled)	Social Security	ity No. Date of Birth			Male Female	
Mailing Address					City,	State, Zip Code			Phone	Number		
									()		
Marital Status Full- □ Single □ Married □ Divorced □ Widowed	time Hire Date	Name of Emp	Sh	oshone Schoo	ool District 312				Email Address			
Dependent Info	<mark>rmation</mark> a	you choose no	t to enrol	l all your eligible far	mily men	bers, you must co	mplete a waive	r form.)				
List all eligible dependents you	wish to enroll, includ	ding any child wh	o is under ti	he age of 26; or who is r	medically c	ertified as disabled ar	nd dependent on p	parent for supp	ort (cop)	y of certification	n required	d).
	Social Security Number Relationship (spouse, child, stepchild, etc.)			Date of Birth (mm/dd/yy)		Male/Female	Type of Enrollment					
Applicant/Employee		/	/	SELF		/ /	☐ Male ☐ Female	Enroll in Der	ntal		🗆 Yes	□ No
For Managed Care Plan	ns Only	Name of Primar select a PCP)	y Care Phy	sician (PCP) or PCP ID I	Number (F	or the highest benefit	level, you must	Existing Pati	98/2003	Office Use (PCP)		
Dependent's Name (first, initial,	last)	/	/			/ /	□ Male □ Female	Enroll in Der	ntal		🗆 Yes	□ No
For Managed Care Plan	Name of Primar select a PCP)	y Care Phy	sician (PCP) or PCP ID	Number (F	or the highest benefit	level, you must	Existing Pati	ent?	Office Use (PCP)			
Dependent's Name (first, initial, last)		/	/			/ /	□ Male □ Female	Enroll in Der	ntal		🗆 Yes	□ No
For Managed Care Plans Only		Name of Primal select a PCP)	y Care Phy	sician (PCP) or PCP ID	Number (F	or the highest benefit	level, you must	Existing Pati		Office Use (PCP)		
Dependent's Name (first, initial,	last)	/	/			/ /	☐ Male ☐ Female	Enroll in De	ntal		🖸 Yes	□ No
For Managed Care Plan	ns Only	Name of Primal select a PCP)	ry Care Phy	sician (PCP) or PCP ID	Number (F	or the highest benefit	level, you must	Existing Pati	ent?	Office Use (PCP)		
Dependent's Name (first, initial,	last)	/	/			/ /	Male Female		ntal		• Yes	□ No
For Managed Care Plan	ns Only	Name of Primar select a PCP)	ry Care Phy	sician (PCP) or PCP ID	Number (F	or the highest benefit	level, you must	Existing Pati	100000	Office Use (PCP)		
Dependent's Name (first, initial,	last)	/	/			/ /	□ Male □ Female		ntal		🗅 Yes	
For Managed Care Plan	ns Only	Name of Prima select a PCP)	ry Care Phy	sician (PCP) or PCP ID	Number (F	or the highest benefit	level, you must	Existing Pati	8853000	Office Use (PCP)		
Type of Enrollm	ient				Change Request							
Health Coverage (check one)	Dental Covera (check one)	ge	Vision Co	National Control of the Control of t	Please	indicate reason fo	or change in cu	irrent enrol	lment b	elow:		
Self only				□ Involuntary loss of group coverage □ Marriage □ Birth □ Adoption								
☐ Self and spouse			32	□ Court order (copy of court order required)								
□ Self, spouse and □ Self, spouse and □ Self, spouse and dependents dependents		Share full sales represented	Other						-			
☐ Self and one dependent	☐ Self and one	dependent	□ Self and	d one dependent	Date ev	rent occurred		1				
☐ Self and two or more dependents	 Self and two dependents 	or more	□ Self and depend	d two or more dents		rent occurred	mm do	i	уу			

Please read the reverse side and sign and date this application.

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FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			М	D	V		
						[

Auditor ___

	dth Statement (Conbility period.)	nplete this h	ealth statement if you	apply for coverage for	yourself or a fo	mily membe	er after the origin	ıal
yet h	e you or any family membe nad? es No	r listed on this	application ever been a	dvised to have any surgica	I operation(s) the	at you or any f	family member have	e not
rega	you or any family member I ardless of whether a physic es □ No				ents, illnesses or	other departu	ures from good heal	lth,
any	ng the past 12 months, have prescribed medication?	ve you or any	family member listed on	this application received a	prescription for r	nedication fro	om a physician or ta	ken
4. Are	you or any family member es 🔲 No If pregnant, wh							
	e you or any family membe	r listed on this	application ever been re	efused or issued restricted	health insurance	coverage?		
	e you or any family membe	er listed on this	application been hospit	alized during the last 5 yea	urs?			
	nin the past two years, have	e you or any m	ember of your family be	en treated for back/joint dis	order?			
alco or n	e you or any family membe hol/drug use or abuse, can ervous disorders or respira es □ No	cer, heart prol	olem/disorder, diabetes,	een told he or she had, bee digestive disorder, immune	en counseled or t disorder, renal/h	reated for any	y of the following: e, strokes, mental	
lf you o	checked YES to any questi	on above, plea	ase provide details below	ı (please use extra paper i	f necessary):			
Item No.	Person Affected	Mo./ Year	Name of Disease, Sympl or Condition – Include Type of Treatme	Name of Hospital an	d Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician
	any person listed on this ap 8 or older)? □ No □ Yes			verage four or more times a	a week within no	longer than th	he past six months	(anyone
				-				
				_				
Cui	rent/Prior Covera	ige (For Cod	ordination of Benefits	, please complete the sec	ction below. Us	e extra pape	er if necessary).	
	u or any of your family men inating your benefits could					complete the	e section below. If co	overage
is prov	rided for a dependent from dent(s)' health care covera	a previous ma	arriage or relationship, pl	ease attach a copy of the	court documental	tion that show	s who is responsible	e for the
	ther Carrier Information: rier Name, Policy Number, Phone Number	Policy	holder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Covera End Da (mm/dd	ate Type of	Will <u>this</u> coverage continue?
		2,270					☐ Medical ☐ Dental	⊒ Yes ⊒ No
							☐ Medical ☐ Dental	⊒ Yes ⊒ No
							☐ Medical ☐ Dental	⊒ Yes ⊒ No
							☐ Medical ☐ Dental	⊒ Yes ⊒ No

Form No. 3-307SWS (06-15)

☐ Medical ☐ Dental ⊒ Yes ⊒ No

Disability Information Are you or any of your dependents currently disabled? YES NO						
	Nature of Disability					
Name of Disabled Person	Physician's Name Physician's Phone Number					
Date of 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 Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately. Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider. Blue Cross of Idaho may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim. If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.	Ny 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 Blue Cross of Idaho. I agree that a facsimile or photocopy of my signature will serve the same as an original. 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. X Applicant's Signature					
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 beidaho.com.	Date					

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