Blue Cross of Idaho®

Idaho School Benefit Trust
Health/Dental/Vision Enrollment Application

Please complete each section of this application in ink.

Requested Effective Date (subject to approval by the Plan) ____________

Group Number 10022355

- ❑ PPO Medical
- ❑ HSA Blue℠ PPO
- ❑ Managed Care Medical POS
- ❑ HSA Blue℠ POS
- ❑ PPO Dental
- ❑ Traditional Dental
- X Dental Blue Connect

Applicant Information (Employee)

Your Name (first, initial, last)	Blue Cross ID No. (if currently enrolled)	Social Security No.	Date of Birth	❑ Male ❑ Female

Mailing Address	City, State, Zip Code	Phone Number

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Full-time Hire Date	Name of Employer	Job Title	Email Address
		Shelley Joint School Distrct No. 60		

Dependent Information (If you choose not to enroll all your eligible family members, you must complete a waiver form.)

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight	Male/Female	Type of Enrollment
Applicant/Employee		SELF				❑ Male ❑ Female	Enroll in Medical ❑ Yes X No; Enroll in Dental X Yes ❑ No; Enroll in Vision ❑ Yes X No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*
Dependent's Name *(first, initial, last)*						❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No; Enroll in Dental ❑ Yes ❑ No; Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*
Dependent's Name *(first, initial, last)*						❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No; Enroll in Dental ❑ Yes ❑ No; Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*
Dependent's Name *(first, initial, last)*						❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No; Enroll in Dental ❑ Yes ❑ No; Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*
Dependent's Name *(first, initial, last)*						❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No; Enroll in Dental ❑ Yes ❑ No; Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*
Dependent's Name *(first, initial, last)*						❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No; Enroll in Dental ❑ Yes ❑ No; Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)						Existing Patient? ❑Yes ❑ No; *Office Use (PCP)*

Type of Enrollment

Health Coverage *(check one)*	Dental Coverage *(check one)*	Vision Coverage *(check one)*
❑ Self only	❑ Self only	❑ Self only
❑ Self and spouse	❑ Self and spouse	❑ Self and spouse
❑ Self, spouse and dependents	❑ Self, spouse and dependents	❑ Self, spouse and dependents
❑ Self and one dependent	❑ Self and one dependent	❑ Self and one dependent
❑ Self and two or more dependents	❑ Self and two or more dependents	❑ Self and two or more dependents

Change Request

Please indicate reason for change in current enrollment below:

❑ Involuntary loss of group coverage ❑ Marriage ❑ Birth ❑ Adoption

❑ Court order (copy of court order required)

Other ____________________

Date event occurred ____________________
mm dd yy

Please read the reverse side and sign and date this application. **OVER ☛**

FOR OFFICE USE ONLY

Group Number	*Subgroup*	*Effective Date*	*Plan ID*			*Class*	*Reason Code*
			M	*D*	*V*		

Auditor ________

Current/Prior Coverage (For Coordination of Benefits, please complete the section below. Use extra paper if necessary).

Do you or any of your family members have other medical and/or dental coverage? ❑ Yes ❑ No

Coordinating your benefits could reduce the amount you owe a provider. For proper coordination of benefits please complete the section below. 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 dependent(s)' health care coverage so that the carrier can determine whose coverage is primary. Use extra paper if necessary.

Other Carrier Information: Carrier Name, Policy Number, Phone Number	*Policyholder Name*	*Names of Covered Members: Self and Dependent(s)*	*Coverage Start Date (mm/dd/yy)*	*Coverage End Date (mm/dd/yy)*	*Type of Coverage*	*Will <u>this</u> coverage continue?*
					❑ Medical ❑ Dental	❑ Yes ❑ No
					❑ Medical ❑ Dental	❑ Yes ❑ No
					❑ Medical ❑ Dental	❑ Yes ❑ No
					❑ Medical ❑ Dental	❑ Yes ❑ No
					❑ 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 Plan.
- 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.
- Plan Administrator may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- Plan Administrator 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 Plan Administrator.
- 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.***
- My employer's summary plan description 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 Plan Administrator.
- 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

_____
Date