Blue Cross of Idaho®

Idaho Small Employer Application Cover Sheet

Welcome to Blue Cross of Idaho

Instructions: This cover sheet must be completed and submitted by your Employer to Blue Cross of Idaho with the completed Idaho Small Employer Application. *Please type or print legibly in black ink and complete all applicable sections.*

SECTION 1 | EMPLOYER INFORMATION

1a. Name of Employer	Requested Effective Date

Your policy effective date will be the first of the month following the date the application is received and approved in our office. If a different effective date is desired, please also indicate that date in the effective date area on the front of the Idaho Small Employer Application. The earliest possible effective date is the first of the month following receipt of the application in our office.

Please note: No applications are made effective until approved by Blue Cross of Idaho.

1b. EMPLOYERS WITH DUAL OPTION:
If your employer offers more than one health insurance plan, please select the plan you want below.

☐ **PPO**_____ ☐ **Managed Care**_____ ☐ **HSA**_____

SECTION 2 | APPLICANT INFORMATION (Employee)

2a. Employee's Name	Social Security No.

2b. Your employer will inform you of your plan offering and who is eligible to enroll in or opt out of dental and/or vision coverage. If your employer offers the choice of enrollment in medical, dental and/or vision, please list each family member enrolling in coverage and indicate if they are enrolling in medical, dental and/or vision. If you have more dependents to include, make a copy of this page and attach.

Member's Name (first, middle initial, last)	*For each plan the dependent enrolls, the Applicant must enroll.*			***For Managed Care Plans Only** (See below-Employers with Managed Care Plans)		
	Enrolling in Medical?	***Enrolling in Dental?*	*Enrolling in Vision?*	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level you must select a PCP)	Existing Patient of PCP?	*Office Use Only PCP*
Applicant	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 1	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 2	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 3	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 4	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 5	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			
Dependent 6	❑Yes ❑ No	❑Yes ❑ No	❑Yes ❑ No			

** EMPLOYERS WITH MANAGED CARE PLANS:* This plan has a network of physicians. Please check the network before signing up. If you are enrolling in a managed care plan (Connect or Point plan), you must select a Primary Care Physician (PCP) for yourself and each covered family member. Each member of your family may choose a different PCP or you may all share the same one.

To help you choose a PCP, you may contact Customer Service toll-free at 800-627-1188, or you may view the provider directory for the plan you are enrolling in on our website:

For Connect Southwest plans visit ***www.bcidaho.com/SaintAlphonsus***
For Connect East plans visit ***www.bcidaho.com/Portneuf***
For Point plans visit ***www.bcidaho.com/POS***

***ESSENTIAL HEALTH BENEFITS DISCLAIMER:* If your employer has selected to offer medical only, please note the following:
The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. You have access to pediatric dental plans, including those offered by Blue Cross of Idaho, as a separate policy. Please contact us, your insurance agent, or Your Health Idaho if you want to learn more about the stand-alone pediatric dental insurance plans available in the market.

Pediatric dental coverage is available for those 18 and under. Additional limitations and waiting periods apply for those ages 19 and older.

P.O. Box 7408 Boise, ID 83707-0938 Enrollment and Billing Services: 800-289-8613 Fax: 208-331-7496

Form No. 3-366A (10-15)

GROUP INFORMATION	Group Number _____ Effective Date _____ Subgroup _____ Class _____

IDAHO SMALL EMPLOYER APPLICATION
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 EMPLOYER/EMPLOYMENT INFORMATION

1. Name of Employer		2. Phone Number ( )	
3. Address	4. City	5. State	6. Zip Code
7. Occupation	8. Hours Worked Per Week	9. Date You Started Work *(mm/dd/yyyy)*	

SECTION 2 APPLICANT INFORMATION (Employee)

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*			
2. Mailing Address *(Street, Route, P.O. Box)*			
3. City	4. State	5. Zip Code	6. County
7. Preferred **Daytime** Phone Number ( )	8. Email Address	9. Date of Birth *(mm/dd/yyyy)*	
10. Gender ☐ Male ☐ Female	11. Social Security Number **(required)**	12. Marital Status ☐ Single ☐ Married ☐ Other _____	

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 3 – Waiver of Coverage.
If you wish to enroll yourself and/or your dependents, please complete all sections except Section 3.

SECTION 3 WAIVER OF COVERAGE *(To be completed only if coverage is declined or refused by an eligible employee or dependents.)*

1. I decline coverage for:

   Self (name)_____ Dependent (name)_____

   Spouse (name)_____ Dependent (name)_____

   Dependent (name)_____ Dependent (name)_____

2. Reason for declining coverage (check all that apply):

   ☐ I and/or my dependents currently have other qualifying medical coverage with (name of carrier)_____

   through: ☐ My other employer ☐ My spouse's employer ☐ Individual policy ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Indian Health Services

   OR ☐ Other reason for declining coverage (please explain):_____

SIGNATURE TO WAIVE**
I have decided to waive coverage as indicated above. I have been given the opportunity to apply for group coverage by the employer. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional probationary waiting periods.

**Signature _____Date *(mm/dd/yyyy)* _____
(sign only if waiving coverage)

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself of your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

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SECTION 4 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents ☐ Enrolling during your employer's open enrollment
2. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, what is the reason *(documentation may be required)*? ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption

   ☐ Involuntary loss of ***employer*** coverage ☐ Involuntary loss of ***individual*** coverage ☐ Involuntary loss of Medicaid

   ☐ Court order *(copy of court order required)* ☐ Other _____

   Date of event *(mm/dd/yyyy)* _____
3. Type of enrollment:

	HEALTH	DENTAL	VISION
Self Only	☐	☐	☐
Self and spouse	☐	☐	☐
Self, spouse & dependents	☐	☐	☐
Self & one dependent	☐	☐	☐
Self & two or more dependents	☐	☐	☐

4. Current employment status:

   ☐ Actively at work ☐ COBRA participant ☐ Disability ☐ Other _____
5. Requested effective date *(Subject to approval): (mm/dd/yyyy)* _____

SECTION 5 DEPENDENT INFORMATION (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). If you have more dependents to include, make a copy of this page and attach.)

Dependent 1

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No		

Dependent 2

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No		

Dependent 3

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No		

Dependent 4

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No		

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Dependent 5

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 5 live at the same address as you? ☐ Yes ☐ No		

Dependent 6

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 6 live at the same address as you? ☐ Yes ☐ No		

SECTION 6 OTHER COVERAGE INFORMATION

(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)

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 insurance so that the insurance carrier can determine whose coverage is primary.

Other Policy

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number			
2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ Dental ☐ Individual ☐ Vision ☐ Medicare	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

SECTION 7 OTHER INFORMATION

1. Are you or any of your dependents listed on this application currently disabled? ☐ No ☐ Yes

   Name of disabled person _____ Physician's name and phone _____

   Date of disability _____ Physician's address _____

   Nature of disability _____

2. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments? ☐ **NO** ☐ **YES**
   If yes, give person's name, specific type and details: _____

   _____

3. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ☐ **NO** ☐ **YES** If yes, list names below:

   _____

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SECTION 8 AFFIRMATION

I affirm the answers in this "Idaho Small Employer Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact on the part of the employer is cause for retroactive termination of coverage by the insurance carrier and/or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

SECTION 9 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:

- No independent producer, agent or employee of the insurance carrier, or of my employer, can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an employer's 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 insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- As proof of status of employment, I authorize my employer to release to the insurance carrier appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan/ contract.
- I agree to abide by the terms of the group's master policy/member certificate, which sets forth all of the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurance carrier.
- 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.

SECTION 10 ACKNOWLEDGMENT

I acknowledge and understand my health plan 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) 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.

Signature of Employee _____ Date *(mm/dd/yyyy)* _____

Signature of Spouse _____ Date *(mm/dd/yyyy)* _____
(if applying for coverage)

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