State of Idaho
Medical Enrollment Application

If you have questions, call:
Department of Administration
Office of Group Insurance
650 W. State Street
Boise, ID 83720-0035
208-332-1860 or 1-800-531-0597
ogi@adm.state.id.us

POLICY TYPE (please check one):

❑ **High Deductible**
❑ **PPO**
❑ **Traditional**

Date of Application: ______________________________

Effective Date *(subject to BCI approval):* ________________

Group Number: 10040000

Please complete *each* section on the front and back page of this application in ink.

Applicant Information (Employee)

Your Name *(first, initial, last)*	Blue Cross ID Number *(if currently enrolled)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	❑ Male ❑ Female

Mailing Address	City, State, Zip Code	Email Address *(for official communications)*

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Hire Date	Rehire Date	Phone Number	State **Department** or agency with which you are employed:

COMPLETE ONLY TO DECLINE ALL BENEFITS *(Do not complete the information below this box.)*
I hereby decline **all** benefits and understand they may be added at a later date and other eligibility requirements as outlined in the State of Idaho member contract and employee handbook.

Signature:____ **Date:**______________________________

Type of Enrollment

MEDICAL

❑ Self only
❑ Self and spouse
❑ Self, spouse and 1 child
❑ Self, spouse and 2+ children
❑ Self and 1 child
❑ Self and 2+ children

Change Request

❑ New Hire
❑ Marriage
❑ Death
❑ Involuntary loss of coverage
❑ Transfer
❑ Divorce
❑ Add Dependent
❑ Court order (copy of court order required)
❑ Adoption
❑ Birth
❑ Delete Dependent

Date event occurred: ____________________

Dental Enrollment*

❑ Self only ❑ Self and dependents

***If I decline dental coverage for my dependents, I understand that they may not be added to coverage until the State of Idaho conducts a special open enrollment period.**

Spouse & Eligible Children to be Enrolled (list all family members you wish to enroll)

Family Member's Name *(first, initial, last)*	Social Security No.	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Social Security No.	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Social Security No.	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	❑ Male ❑ Female
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Family Member's Name *(first, initial, last)*	Social Security No.	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	❑ Male ❑ Female

Is spouse a State of Idaho employee? **❑ YES ❑ NO If YES, spouse's name:** ______________________________

Social Security Number: ______________________ **Department:** ______________________________

SPOUSE MUST COMPLETE A SEPARATE APPLICATION TO ENROLL OR TO DECLINE COVERAGE.

OVER ☛

Original applications must be submitted to your AGENCY HUMAN RESOURCES OFFICE

FOR OFFICE USE ONLY

Auditor __________

Form No. 3-700 (09-15)

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Current/Prior Coverage Information (Please complete for proper coordination of benefits administration.)

Is any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy? ❑ Yes ❑ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Start Date of Policy (mm/dd/yy)	Will Current Policy Continue?*
Employee					❑ Yes ❑ No
Spouse					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No

If any person listed on this application is covered by Medicare, please complete the following:

Name ____________ Medicare Beneficiary Number ____________ Reason for Medicare Entitlement (age, disability of ESRD) ____________

Date of Medicare Entitlement: Part A ____________ (mm dd yy) Part B ____________ (mm dd yy)

* If your current coverage will remain active, please indicate if coverage is for: ❑ Medical ❑ Dental ❑ Vision

* If your current coverage will be terminated, please indicate termination date: ____________ (mm dd yy)

Disability Information

Total disability is a condition resulting from disease or accidental injury, as certified in writing by an attending physician, that renders the enrollee/member incapable of performing the principal duties of regular employment/occupation for which he/she is qualified/trained and he/she is not engaged in any work, profession or avocation for fees, gain or profit; or he/she is unable to engage in the normal activities of an individual of the same age and gender.

Are you or any of your dependents currently *totally* disabled? ❑ YES ❑ NO *(If YES, complete information below.)*

Nature of Total Disability ____________

Name of Totally Disabled Person ____________ *Physician's Name* ____________ *Physician's Phone Number* ____________

Date of Total 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 the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- 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 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 the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- 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.
- I have read and understand the group health plan dependent eligibility requirements and further understand that I am required at the time a dependent loses eligibility to submit an application removing the ineligible dependent from coverage within thirty (30) days. I further understand and agree that failure to do so may result in recovery of benefits to the extent allowable by law.

APPLICATION MUST BE SIGNED AND DATED

Signature____________

Date____________