Regence

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

State of Idaho Retiree Spouse Medical Application

If you have questions, contact:
Department of Administration
Office of Group Insurance
208-332-1860 or 1-800-531-0597
ogi@adm.idaho.gov

Please complete each section on this application in black ink.

Date of Application: _____

Effective Date: _____

Group Number: **10060598**

Method of Payment

☐ **Withhold premium from my spouse's sick leave/retirement benefit**

☐ **Have Regence bill me**

SECTION 1 – APPLICANT INFORMATION (Retiree's Spouse) (You must be under age 65) **Please populate all fields**

Applicant Last Name	First Name	Middle Initial

Regence ID Number (if currently enrolled)	Social Security Number	Date of Birth	Gender
			☐ Male ☐ Female ☐ Non-binary/Other

Retiree's Name (first, initial, last)	Social Security Number	Date of Birth

Mailing Address	City	State	ZIP

Primary Language	Daytime Phone Number	Email Address - to receive important information

Marital Status:	Retiree's Agency/School District
☐ Single ☐ Married ☐ Divorced	

Retiree's Initial Hire Date (mm/dd/yyyy)	Retiree's Employment Termination Date (mm/dd/yyyy)	Retiree's Amount of Monthly Retirement Benefits	Retiree's Credited State Service Hours on Last Day Worked

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.

Signature: _____ **Date:** _____

SECTION 2 – Eligible Dependents for Whom Coverage is Being Elected (Dependents must be under age 65)

Name (first, middle, last)	Relationship	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Coverage Updates
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes
				☐ M ☐ F ☐ O*	☐ Enroll ☐ Disenroll ☐ No Changes

*O = Non-binary/Other

SECTION 3 – CURRENT AND 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 Shield of Idaho policy? ☐ YES ☐ NO If **YES**, please complete all information below for **each** person listed on this application.

Name of Covered Member(s)	Name of Carrier	Policy Number	Type of Policy	Policy Start Date (mm/dd/yyyy)	Will Policy Continue?†
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO
			☐ Group ☐ Individual ☐ Medicare		☐ YES ☐ NO

†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/yyyy): _____

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

Name	Medicare	Reason for Medicare Entitlement
	☐ Part A ☐ Part B ☐ Part D	☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

SECTION 4 – ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or termination of coverage as indicated above. Any coverage will be under the master contract between Regence and my employer and subject to the terms and conditions of the certificate issued under it. I agree to the employer's enrollment provisions and certify that those I seek to enroll meet the eligibility criteria. I understand that coverage does not start until I serve the employer's eligibility waiting period established in Regence's records.

I waive coverage of any eligible individual not listed on this application. Spouses of retirees can enroll within the 60 days for seamless coverage or at any time after the 60 days for a first of the month following the application date effective date, if they still meet the eligibility requirements at the time they want to enroll. Please call 1-800-505-6801 for more information about these rules.

This application will become part of the contract between Regence and my employer and I understand only an officer of Regence may change the terms of the master contract, its amendments, or this application. 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 an 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, or insurance information requested for any enrolled member. I acknowledge and understand that Regence may request or disclose health information, other than psychotherapy notes (for which a separate authorization will be used), about me or my enrolled dependents from time to time to facilitate health care treatment or payment, to assist with business operations necessary to administer health care benefits, or as required by law. More information about Regence's uses and disclosures of information is provided in its Notice of Privacy Practices, available at regence.com or by calling customer service.

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

I certify that all information provided on this form is true, correct, and complete, and understand Regence will rely on it in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance or benefits.

SECTION 5 – APPLICANT SIGNATURE

I have reviewed and agree to the provisions set out in Section 4 – Acknowledgments and Authorizations above.

Applicant Signature: _____ **Date:** _____

Regence BlueShield of Idaho: 1602 21st Avenue, Lewiston, Idaho 83501