



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



## State of Idaho Retiree Medical Plan Enrollment Application

Remit Application To:  
Office of Group Insurance  
PO Box 83720  
Boise, ID 83720-0035

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

Date of Application: \_\_\_\_\_

Date of Retirement: \_\_\_\_\_

Date Active Employee Coverage Ends: \_\_\_\_\_

Retiree Plan Effective Date: \_\_\_\_\_

Please complete each section on this application in black ink.

Group
<input type="checkbox"/> PERSI Retirees (50006049) <input type="checkbox"/> Retiree Direct Pay (50006048)

**POLICY TYPE (please check one):**     High Deductible     PPO     Traditional

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

Employee Last Name		First Name		Middle Initial	Regence ID Number (if currently enrolled)	
Social Security Number			Date of Birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Other	
Employee Mailing Address				City	State	ZIP
Primary Language	Daytime Phone Number		Email Address - to receive important information			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Retiree's Agency/School District				
Initial Hire Date (mm/dd/yyyy)	Most Recent Hire Date (mm/dd/yyyy)	Amount of Monthly Retirement Benefits		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
				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O*	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll <input type="checkbox"/> No Changes
				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O*	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll <input type="checkbox"/> No Changes
				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O*	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll <input type="checkbox"/> No Changes
				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O*	<input type="checkbox"/> Enroll <input type="checkbox"/> Disenroll <input type="checkbox"/> 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?†
			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare		<input type="checkbox"/> YES <input type="checkbox"/> 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
	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement <input type="checkbox"/> 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. 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

