Blue Cross of Idaho

State of Idaho Retiree Medical Plan Enrollment 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 the front and back page of this application in ink.

Date of Application_____
Date of Retirement _____
Date Active Employee Coverage Ends _____
Retiree Plan Effective Date_____
(subject to BCI approval)

Group Number: **10040000**

POLICY TYPE (please check one):

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

Applicant Information (Retiree) (You must be under age 65)

Your Name *(first, initial, last)*	Blue Cross ID Number *(if currently enrolled)*	Social Security Number / /	Date of Birth / /	❑ Male ❑ Female
Mailing Address	City, State, Zip Code		Phone Number ( )	
Marital Status: ❑ Single ❑ Married	State **Agency** or department from which you are retired			
Initial Hire Date	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:_____

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

Name	Relationship	Birthdate	Social Security Number

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?*
Retiree					❑ 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

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		
10040000							

Auditor _____

Form No. 3-701a (02-18)

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.**

APPLICATION MUST BE SIGNED AND DATED

Signature_____

Date_____

RETURN COMPLETED APPLICATION TO OFFICE OF GROUP INSURANCE
P.O. BOX 83720 BOISE, ID 83720-0035