# Group Plan 65®

## Member Enrollment Request Form

**Please be sure to complete ALL information below to avoid delays in processing.**

### Section 1 - Employer Information (To be completed by plan administrator.)

| Group Name | | Effective Date ____/____/____ MM / DD / YYYY |
|---|---|---|
| Group # | Subgroup # | |

### Section 2 - Please Provide Personal Information (Please Print)

| ☐ Mr. ☐ Mrs. ☐ Ms. | Last Name | First Name | Middle Initial |
|---|---|---|---|

| Birth Date ____/____/____ MM / DD / YYYY | Sex ☐ M ☐ F | Home Phone Number ( ) | Cell Phone Number ( ) |
|---|---|---|---|

| Social Security Number* ____-____-______ XXX - XX - XXXX | Current BCBSRI ID (if applicable) | What is your primary language spoken? |
|---|---|---|

**Permanent Residence Street Address** (P.O. Box is not allowed)

| City | State | ZIP Code |
|---|---|---|

**Mailing Address** (only if different from your Permanent Residence Street Address)

| City | State | ZIP Code |
|---|---|---|

**Email Address**

### Section 3 - Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

Name (as it appears on your Medicare card):

______________________________

Medicare Number: ______________________________

Is Entitled To: Effective Date:

HOSPITAL (Part A) ______________________

MEDICAL (Part B) ______________________

You must have Medicare Part A and Part B to join a Medicare Supplement plan.

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/

## Section 4 - Please Provide Your Current or Prior Insurance Information

| What is the name of your current or prior health insurance carrier? ______________________ | When will your medical coverage end? _____/_____/_____ MM / DD / YYYY<br>Please attach a copy of your Certificate of Creditable Coverage showing the coverage end date, unless you are enrolled with BCBSRI or are new to Medicare Part B. **Application will not be processed until received.** |
|---|---|

## Section 5 - Eligibility

1. Are you transferring from an out-of-state Blue Cross Blue Shield plan? ☐ Yes ☐ No
   If yes, please include: the state, company name, and subscriber ID:
   State: ______________________
   Company Name: ______________________
   Subscriber ID: ______________________

2. Are you enrolled in another health insurance plan? ☐ Yes ☐ No
   If yes, please answer the following questions:
   Name of policy holder with other insurance: ______________________
   Relationship: ______________________
   Policy/contract number: ______________________
   Name of employer who offers this coverage: ______________________
   Address of employer who offers this coverage: ______________________
   Name of other insurance company: ______________________
   Address of other insurance company: ______________________

## Section 6 - Please Read and Sign Below

**By completing this enrollment application, I certify and agree that:**

By signing this form, I certify the information is true and complete to the best of my knowledge.

**Signature:** ______________________ **Today's Date:** ______________________

## Internal Use Only – To Be Completed by Agent

| ☐ New ________ ☐ TConv ________ | ☐ Other: ________ |
|---|---|
| Sales Agent Signature (if assisted in enrollment) | Agent Received Date |
| Print Sales Agent Name | Broker ID# |
| | Effective Date of Coverage _____/_____/_____. (MM / DD / YYYY) |