

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)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First Name	Middle Initial
Birth Date	Sex	Home Phone Number	Cell Phone Number
____/____/____ MM / DD / YYYY	<input type="checkbox"/> M <input type="checkbox"/> F	()	()
Social Security Number*	Current BCBSRI ID (if applicable)	What is your primary language spoken?	
____-____-____ XXX - XX - XXXX			

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

City	State	ZIP Code
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Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code
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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

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

<input type="checkbox"/> New _____ <input type="checkbox"/> TConv _____ <input type="checkbox"/> Other: _____	
Sales Agent Signature (if assisted in enrollment)	Agent Received Date
Print Sales Agent Name	Broker ID#
	Effective Date of Coverage ____/____/____ (MM / DD / YYYY)

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