



Regence

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



Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, UT 84130-0270

Application For Enrollment/Change

Please print in black or blue ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." The form must be signed and dated or it will be returned. The five boxes directly below should be completed by the Group Administrator.

Table with 5 columns: Health Group Number, Subgroup, Group Name, Requested Effective Date, Class. Group Name: Utah State University

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

New Enrollment: MEDICAL: [ ] Applicant Only [ ] Applicant and one Dependent [ ] Applicant and 2+ Dependents. DENTAL: [ ] Applicant Only [ ] Applicant and one Dependent [ ] Applicant and 2+ Dependents

New Enrollment due to: [ ] New Hire [ ] Open Enrollment [ ] Early Retiree [ ] COBRA (For COBRA, a reason for cancellation must be selected below)

Product: [ ] Wellness Plan (White) [ ] High Premium Plan (Blue) [ ] High Deductible Choice Plan (HSA)\* [ ] Dental

\* Your HSA is your financial asset even if you change employers or health plans. To open an HSA you must meet three criteria: 1. You must be covered by a qualified high deductible health plan. 2. You cannot be covered by another health plan, including Medicare and; 3. You cannot be claimed as a dependent on another individual's tax return. If you do not want an HSA opened for you or you do not qualify for an HSA select this box. [ ]

Note: USU will only do payroll deductions into an HSA that is located at HealthEquity. If you have an existing HSA with another administrator contact HealthEquity to assist with rolling your HSA over to HealthEquity (866-960-8055).

Change: [ ] Add applicant with/without dependent(s) [ ] Add dependent(s) only - Applicant must already be enrolled

Change due to: [ ] Name Change [ ] Address Change [ ] Birth [ ] Marriage [ ] Adoption [ ] Open Enrollment Changes [ ] Loss of Eligibility on another plan [ ] Court Order [ ] Other reason. Date of Change Event (required)

Cancellation: [ ] All Dependent(s) [ ] Cancel Dependent(s) - list:

Cancellation due to: [ ] Dependent no longer eligible [ ] Divorced [ ] Death [ ] Medicare Entitlement [ ] Termination of Employment [ ] Reduction of Hours [ ] Military Leave [ ] Other reason. Date of Cancellation Event (required)

SECTION 2 - EMPLOYEE INFORMATION

Employee information form including fields for Applicant Last Name, First Name, Middle Initial, Mailing Address, Physical Address, City, State, and ZIP Code, Daytime Telephone Number, Social Security Number, Full-time Date of Hire, Hours Per Week, Employer (Utah State University), Date of Birth, Gender, Marital Status, Primary Language, E-mail Address, and member card type.

SECTION 3 - ENROLLING DEPENDENTS

Table for enrolling dependents with columns: Gender, Name(s) of Individual(s) to be Covered, Medical, Dental, Relationship to Applicant, Social Security Number, Birthdate Mo/Day/Yr.

If you need extra space, please request an additional form from your group administrator. If you and your spouse are divorced or legally separated, please indicate below who has Legal custody of your child(ren):

SECTION 4 - CHILD CUSTODY INFORMATION

Table for child custody information with columns: Name of Child(ren), Father, Mother, Joint, Other, Date awarded, Is the parent without custody required by court decree to provide coverage for the dependent children? Yes No. If "Yes" list other coverage provided.



**Application For Enrollment/Change (continued)**

**SECTION 5 - CURRENT/PRIOR COVERAGE INFORMATION**

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE.

**MEDICARE** If you or any family members listed on this application have Medicare, is coverage  Part A  Part B  Part D, and please complete the following information:

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Entitlement

Applicant's Name (Non-Medicare)	Insurance Carrier (Policy Number and Phone Number)	Date of Coverage Month/Day/Year		Will coverage continue?	Type of Coverage	
		From	To		<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
6.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical
7.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Medical

If you need extra space, please request an additional form from your group administrator.

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the self-insured plan maintained by my employer (for which Regence BlueCross BlueShield of Utah provides claims administration services, but does not assume financial risk or obligation) and I agree to the terms and conditions of that plan. I agree to abide by the plan's enrollment provisions and certify that all those whom I seek to enroll, including myself, meet the plan's eligibility criteria. I understand that coverage cannot start until after I have served any eligibility waiting period included in the plan.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period and/or certain qualifying events under Section 125.

If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. I may also enroll waived individuals within 60 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement. To obtain more information about these rules, please call 1 (800) 505-6801.

Except by express and duly authorized amendment to the plan, no person may change the terms of the plan. No person may waive the requirement that I answer all questions on this application completely and accurately.

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 acting as agent for Regence BlueCross BlueShield of Utah. 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 BlueCross BlueShield of Utah, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence BlueCross BlueShield of Utah may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed 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. Health information requested or disclosed may be related to treatment or services performed by:

- ◆ A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ◆ A clinic, hospital, long term care or other medical facility;
- ◆ Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- ◆ An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

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

I understand that a waiting period for coverage of preexisting conditions may apply. A preexisting condition waiting period may be reduced by any prior creditable health coverage I and/or my dependent(s) may have had, as long as there was not a significant lapse in coverage. I have the right to provide evidence of prior coverage. I can contact Regence BlueCross BlueShield of Utah for assistance in obtaining proper evidence of prior coverage.

I have provided these answers as part of the application procedure for the plan and I certify that all information completed on this form is true, correct, and complete. I understand that the plan will rely on each answer in making coverage and rating determinations. For the protection of all enrollees, fraud or misrepresentation of material fact by me for the purposes of defrauding the plan may result in the plan taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform the plan in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

