Regence

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

Regence BlueCross BlueShield of Utah
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

Application For Enrollment/Change/Waiver (for self-insured groups)

Please print in black 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.

Group Number	Subgroup	Class	Group Name	Requested Effective Date
			Roman Catholic Bishop of SLC	

Employee Last Name	First Name	Middle Initial

NOTICE: WAIVER OF COVERAGE Individuals waiving coverage complete only Section 7

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date _____

☐ Eligibility Waiting Period Start Date _____

CHANGE

Change:

☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Reason for change* _____

*Reasons include: birth, marriage, divorce, death, adoption, dependent change (add or drop), involuntary loss of other coverage.

Date of Change Event

Demographic Information Change: ☐ Name Change ☐ Address Change ☐ Other _____

CANCELLATION

Cancellation: (select cancellation reason and enter cancellation date below)

☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)

☐ Cancel Dependent(s) - List: _____

SECTION 2 - PLAN SELECTION

MEDICAL PLAN CHOICES

MEDICAL:

☐ **General BluePoint** - Preferred ValueCare (PVC)

☐ **General BluePoint** - Participating (PAR)

☐ **HDHP** - Preferred ValueCare (PVC)

☐ **HDHP** - Participating (PAR)

☐ **Lay**

☐ **Religious**

DENTAL: **Dental Expressions:** Included with Medical

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Application For Enrollment/Change (continued)

SECTION 3 - EMPLOYEE INFORMATION

Mailing Address		City, State, and ZIP Code	
Physical Address ☐ Same as Mailing Address		City, State, and ZIP Code	
Date of Birth	Hours Per Week	Primary Language	Full-time Date of Hire
Gender: ☐ Female ☐ Male	Social Security Number	Daytime Telephone Number ( )	Original Date of Hire

Marital Status: ☐ Single ☐ Divorced ☐ Married

Go paperless! Regence can send secure communications about your insurance claims and benefits to a Regence.com account! Once registered, an email or text (your choice) will notify you when a new communication is posted.
Yes, please set up an account for me and email me a link to access and personalize it.

My email address: _____

SECTION 4 - ENROLLING DEPENDENTS

Gender	Dependent Name (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number	Birthdate Mo/Day/Yr
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			
☐F ☐M		☐	☐			

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

SECTION 5 - CURRENT AND PRIOR COVERAGE

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of any court documentation that shows who is responsible for the health care insurance of the dependent(s) so that the carrier can determine which coverage should pay first.

Name of Covered Members and Policy Information	Will Coverage Continue?	Product and Coverage Type
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ Part A ☐ Part B ☐ Part D
Member Names: Carrier Name: Carrier Phone: Policy Number: Dates of Coverage: ___/___/___ to ___/___/___	☐ Yes ☐ No	**Coverage Type:** ☐ Group ☐ Individual **Product Type:** ☐ Medical ☐ Dental **Medicare:** ☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement (if applicable): ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

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Applicant signature

I certify that all information provided on this form is true, correct, and complete. In addition, I have reviewed and agree to the provisions set out in the Acknowledgments and Authorizations section below.

Applicant Signature:_____ Date: _____

SECTION 6 - ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or cancellation 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. I, or any other waived individual, may enroll at a later time during my group's anniversary or a Special Enrollment Period. If I waive enrollment for myself or any of my dependents because of other health insurance coverage, I may enroll the waived individuals if I request enrollment within 30 days after the other coverage ends. I may also enroll waived individuals within 30 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, I may enroll myself and or new dependents within 30 days of marriage, or within 60 days of birth, adoption, or placement for adoption. 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, and/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 purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance and/or benefits.

Regence BlueCross BlueShield of Utah: 2890 E. Cottonwood Parkway, Salt Lake City, Utah 97207-1271

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SECTION 7 - WAIVING COVERAGE

EMPLOYEE INFORMATION

Name (Last, First, Middle)	Social Security Number	Date of Birth

Date of Hire	Average number of hours worked per week	Waiving coverage for:
		☐ Employee ☐ Employee/Dependent(s) ☐ Dependent(s) Only

I have been offered coverage under my group's plan through Regence BlueCross BlueShield of Utah (Regence), but I am waiving coverage for the following reason(s). **Check all that apply:**

☐ I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time.

☐ I currently have medical coverage elsewhere:

Carrier _____ **Policy Number** _____

Member ID Number _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

☐ I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time.

☐ I currently have dental coverage elsewhere:

Carrier _____ **Policy Number** _____

Member ID Number _____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ TriCare ☐ Other _____

If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier, Policy Number or Member ID Number, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits).

Name of Individual Waiving Coverage	Carrier	Policy Number	Member ID Number

HEALTH INFORMATION

Is any applicant pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? ☐ Yes ☐ No

If currently pregnant, provide expected due date _____ (mm/dd/yyyy)

Do you anticipate complications or multiple births? ☐ Yes ☐ No

Have you had prior complications or multiple births? ☐ Yes ☐ No

If you are waiving coverage under this medical/dental plan for yourself and/or your dependent(s) because of other health insurance, you may be able to enroll yourself and your dependent(s) under this plan if you or your dependent(s) lose eligibility for that other coverage or an employer stops contributing towards other group coverage, provided that you request enrollment within 30 days after you or your dependent's other coverage ends or employer contributions stop. You may also enroll waived individuals within 30 days of receiving initial written notice of eligibility for premium assistance under Title 26, Chapter 18 of the Utah Code. In addition, if you waive enrollment under this medical/dental plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage or within 60 days after the birth, adoption, or placement for adoption. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan through Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I have provided these answers as part of the application process required by the Issuer to waive coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence will rely on each answer in making coverage and rating determinations. For protection of all members, knowingly providing false, incomplete, or misleading information for the purposes of defrauding Regence may result in Regence 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 Regence in writing if anything changes before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

► _____ _____

Signature of Employee Date

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)