Group Dependent Addendum

Blue Cross Blue Shield of Rhode Island

Please complete the following for additional dependants and attach it to the Group Member Application.

Employer group name_____ Group number_____ Dept. number_____

Employee name_____ Social security number_____-_____-_____

Phone number_____-_____-_____ Effective date_____-_____-_____

Dependent Information

Dependent #6

Last name _____First name _____ M.I. _____Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number[1] _____-_____-_____

Primary care physician (PCP) name, address _____

_____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

Dependent #7

Last name _____First name _____ M.I. _____Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number[1] _____-_____-_____

Primary care physician (PCP) name, address _____

_____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

Dependent #8

Last name _____First name _____ M.I. _____Suffix _____

Relationship ☐ Son ☐ Daughter Coverage applied for: ☐ Medical ☐ Dental ☐ Vision

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Social security number[1] _____-_____-_____

Primary care physician (PCP) name, address _____

_____

Is this dependent a current patient of the PCP listed above? ☐ Yes ☐ No

[1]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/Overview.html

(continued)

Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

SIGN HERE ☞

Signature of Applicant or signature of parent or guardian *if applicant is under 18 years of age* _____ Date

Application rec'd date_____ ID #_____

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Blue Cross Blue Shield of Rhode Island

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