Regence

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

Regence BlueCross BlueShield of Oregon
Mail form to: PO Box 1106
Lewiston, ID 83501
Fax to: 1-866-303-5117
Email to: Regence_Membership@regence.com

Application for Enrollment/Change (for groups 1-50)

Please print in black ink. Incomplete 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.**

GROUP ADMINISTRATOR: This section should be completed by the Group Administrator.				
Group Number	Subgroup	Class	Group Name	Requested Effective Date
Hours Per Week	Original Date of Hire	Full Time Date of Hire	Eligibility Waiting Period Start Date	

SECTION 1 – NEW ENROLLMENT, CHANGE OR TERMINATION (Please populate all fields)			
Employee Last Name	First Name		Middle Initial
Employee Mailing Address	City	State	ZIP
Employee Physical Address (same as mailing ☐)	City	State	ZIP
Primary Language / Daytime Phone Number	Email Address - to receive important information		

Marital Status: ☐ Single ☐ Married/Registered Domestic Partnership ☐ Divorced ☐ Non-Registered Domestic Partnership (must submit an Affidavit of Qualifying Domestic Partnership)

New Enrollment/Termination

Date of Event: _____

- ☐ New Group/New Hire
- ☐ Open Enrollment
- ☐ Rehire
- ☐ Termination

Special Enrollment

Date of Event: _____

- ☐ Birth/Adoption
- ☐ Loss of Coverage (complete Section 5)
- ☐ Marriage/Eligible Domestic Partnership
- ☐ Other _____

Changes

- ☐ Name Change
  - New Name: _____
  - Old Name: _____
- ☐ Address Change (enter above)
- ☐ Plan Selection

SECTION 2 – PLAN SELECTION

Refer to your Group Administrator for plan options available to you.

Dental	**Medical**
☐ Dental ☐ No Dental	Select metal level: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ No Medical
	Select your network: ☐ Preferred ☐ Legacy
	If your group has more than one medical plan, enter your deductible amount: $_____

HSA (health savings account) health plans only: If your employer has partnered with HealthEquity for your HSA bank account, it will be created for you automatically. No further action is required from you; however, you have the following alternative options:

- ☐ Send my claims data to HealthEquity. I have read and agreed to the *HSA Authorization Form* found on regence.com.
- ☐ No, I don't want a HealthEquity HSA.

SECTION 2 – PLAN SELECTION (continued)

Standardized Plans Only: Federal law requires you to have pediatric dental benefits (for any person under age 19), but Oregon law forbids them in standardized plans. We cannot issue you a standardized plan without assurance below that you and all those for whom you are applying have or will have an Exchange-certified pediatric dental plan.

☐ By checking this box, I provide my assurance that I have pediatric dental plan coverage of the type, and for all persons, described above.

SECTION 3 – ENROLLING MEMBERS

List all members for whom you are adding, changing or terminating Medical (M) or Dental (D) benefits.

Add	Term	Benefit	Gender	Name (First,Middle,Last)	Social Security Number	Date of Birth	Relation
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*	**Employee/Subscriber**			**SELF**
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				
☐	☐	☐ M ☐ D	☐ M ☐ F ☐ O*				

*O = Non-binary/Other

This confirms that any employee or dependent for whom retroactive termination for administrative delay is requested had no expectation of coverage and paid no premium after the requested termination date.

Group Administrator Signature: _____ **Date:** _____

SECTION 4 – COBRA OR NON-COBRA CONTINUATION ENROLLMENT

You or your dependents may be entitled to COBRA or Non-COBRA continuation due to loss of current coverage. Select an option for continuing coverage below, or select "None" if not electing.

Reasons for entitlement include loss of coverage due to: Termination of employment; Enrolled child no longer eligible; Medicare entitlement; Reduction of hours; Divorce/termination of Domestic Partnership; Death.

Type of Continuation: ☐ COBRA ☐ Non-COBRA Continuation ☐ None

Reason for Entitlement: _____ Date of Event: _____

SECTION 5 – CURRENT AND PRIOR COVERAGE

Names of Covered Members	Health Insurance Carrier	Dates of Coverage	Coverage Continuing?	Coverage and Product Type
	Carrier Name: Policy Number: Carrier Phone:	Begin: End:	☐ 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

Note: If coverage is provided for an enrolled child or children from a previous marriage or relationship, please attach a copy of any court documentation that shows who is responsible for the health care expenses or insurance of the child(ren) so that the carrier can determine which coverage should pay first.

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

SECTION 6 – APPLICANT SIGNATURE

I have reviewed and agree to the provisions set out in Section 7 – Acknowledgments and Authorizations below.

Applicant Signature: _____ Date: _____

SECTION 7 – ACKNOWLEDGMENTS AND AUTHORIZATIONS

I hereby apply for enrollment, change, or termination 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 annual open enrollment period 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. In addition, I may enroll myself or new dependent(s) within 30 days of marriage or domestic partnership, 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, 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 contracted 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. For the protection of all members, fraud or misrepresentation of material fact by me for the purpose of defrauding Regence may result in Regence taking any action allowed by law or contract, including termination or rescission of coverage or denial of benefits, or could subject me to prosecution for insurance fraud.

Regence BlueCross BlueShield of Oregon: 100 SW Market Street, Portland, OR 97201

Race and Ethnicity Survey

We are committed to advancing health equity for our members. Obtaining race and ethnicity information can help bridge healthcare gaps in traditionally underserved communities.

The race and ethnicity information provided will be exclusively used to improve services to our members. Answers are not required, and information provided will not affect member eligibility, plan choices, or access to programs.

Employee/Subscriber Name	Group Name	Group Number

☐ Check this box if the Race and Ethnicity responses would be the same for the Employee/Subscriber and any active enrolled family members.

Race and Ethnicity Survey

Employee/Subscriber Name:

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define)	☐ Salvadoran
☐ Korean	_____	☐ Other _____
	☐ Prefer not to answer	☐ Prefer not to answer

Dependent Name

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define)	☐ Salvadoran
☐ Korean	_____	☐ Other _____
	☐ Prefer not to answer	☐ Prefer not to answer

Dependent Name

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define)	☐ Salvadoran
☐ Korean	_____	☐ Other _____
	☐ Prefer not to answer	☐ Prefer not to answer

Race and Ethnicity Survey (Continued)

Employee/Subscriber Name	Group Name	Group Number

Dependent Name

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define) ________	☐ Salvadoran
☐ Korean	☐ Prefer not to answer	☐ Other ________
		☐ Prefer not to answer

Dependent Name

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define) ________	☐ Salvadoran
☐ Korean	☐ Prefer not to answer	☐ Other ________
		☐ Prefer not to answer

Dependent Name

Race		Ethnicity
☐ American Indian/Alaskan Native	☐ Vietnamese	☐ Hispanic or Latino/a
☐ Asian Indian	☐ Native Hawaiian	☐ Not Hispanic or Latino/a
☐ Black or African American	☐ Samoan	☐ Cuban
☐ Chinese	☐ White	☐ Guatemalan
☐ Filipino	☐ Other Asian	☐ Mexican, Mexican American, Chicano/a
☐ Guamanian or Chamorro	☐ Other Pacific Islander	☐ Puerto Rican
☐ Japanese	☐ Other (please define) ________	☐ Salvadoran
☐ Korean	☐ Prefer not to answer	☐ Other ________
		☐ Prefer not to answer

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, koji' 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)