Regence

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

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

Utah Small Employer Application Cover Sheet for Groups 1-50

(To be used with the Utah Small Employer Health Insurance Application)

Please print in black ink.

GROUP ADMINISTRATOR: This section should be completed by the Group Administrator.			
Group Number	Subgroup	Class	Group Name

Requested Effective Date	Eligibility Waiting Period Start Date

Employee Last Name	First Name	Middle Initial

SECTION 1 – ENROLL, WAIVE OR CHANGE COVERAGE

Check those that apply:

- ☐ New enrollment for employee and/or dependents
- ☐ Waive coverage for employee and/or dependents (complete Waiver of Coverage in the Utah State Application)
- ☐ Change plan
- ☐ Change name – former name: _____
- ☐ Change address (enter new address on the Utah State Application)

SECTION 2 – PLAN SELECTION

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

Dental	**Medical**
☐ Dental	Select your metal level: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ No Medical
	Select your network: ☐ FocalPoint ☐ Preferred ValueCare ☐ Participating
☐ No Dental	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*.
- ☐ No, I don't want a HealthEquity HSA.

List all members for whom you are adding Medical and/or Dental benefits.

Relationship	**Name (First, Middle, Last)**	**Benefit**
Employee/Subscriber	Employee/Subscriber	☐ Medical ☐ Dental
Spouse/Domestic Partner		☐ Medical ☐ Dental
Dependent		☐ Medical ☐ Dental
Dependent		☐ Medical ☐ Dental
Dependent		☐ Medical ☐ Dental

SECTION 3 – TERMINATE COVERAGE

Complete this section only if you are requesting to terminate coverage for yourself or your dependent(s).

Terminate coverage as of (date)_____ for:

☐ employee/subscriber and all dependents.

☐ all dependents.

☐ only listed dependents: _____

This confirms that any employee and/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 and/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 MEDICARE COVERAGE

If you or any family members listed on this application have Medicare, please complete this section:

Name of Covered Member	Medicare Number (include alpha suffix)	Effective Date	Coverage Type (check all that apply)
			☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

Name of Covered Member	Medicare Number (include alpha suffix)	Effective Date	Coverage Type (check all that apply)
			☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

Any accompanying foreign language version of this form is provided only as an accommodation or courtesy to the customer and this English language version shall control the resolution of any dispute or complaint.

Regence BlueCross BlueShield of Utah: 2890 E Cottonwood Parkway, Salt Lake City, UT 84121

UTAH SMALL EMPLOYER
EMPLOYEE HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)

☐ New Group	☐ Newborn	☐ Loss of Coverage_____
☐ Open Enrollment	☐ Court Order	☐ Marriage_____
☐ New Hire	☐ Dependent Addition	☐ Divorce_____
☐ New Application	☐ Other:_____	☐ Military Leave of Absence(USERRA)_____
☐ COBRA	☐ Utah mini-COBRA	

Length of continuation coverage: ☐12 mos. ☐18 mos. ☐36 mos. ☐Other:

Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

☐ WAIVER OF COVERAGE Individuals waiving coverage complete Waiver of Coverage.

A. EMPLOYER INFORMATION

Employer _____ Is this a division? ☐Yes ☐No If "Yes," name of parent company_____

B. EMPLOYEE INFORMATION

Name (Last) _____ (First)_____ (MI) _____ Job Title _____ Hrs/Week _____

Employment status ☐Full-time ☐Owner/business partner ☐Retired ☐Other_____ Hire Date_____ Rehire Date_____

Marital Status ☐Legally Married ☐Single ☐Divorced ☐Widowed ☐Domestic Partner*

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home/Cell Phone (____) _____ Business Phone (____) _____ Email Address: _____

If you are American Indian or Alaska Native, provide the state and name of your federally-recognized tribe: _____

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all dependents applying for coverage. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use:
Employee				☐ Male ☐ Female	☐ Yes ☐ No
Spouse/ Domestic Partner*				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No
Dependent				☐ Male ☐ Female	☐ Yes ☐ No

*Check with your employer to determine if domestic partner coverage is available.

D. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, Medicaid, or Medicare currently in effect. This will be used to determine if benefits will be coordinated. Each person applying for coverage must be listed below. If no health care coverage is in effect, indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Employee:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Spouse/Domestic Partner:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____
Dependent:				☐ Yes ☐ No	☐ Employer group ☐ Individual ☐ Medicare ☐ Governmental ☐ Other_____

E. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after the waiting period. I authorize my employer to act as my agent in all matters of administration of the group program.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible dependents.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, correct and complete. I acknowledge that if any information provided is false, the insurer may without advance notice pursue any remedies available under state or federal law, including declaring the coverage null and void and canceling the coverage retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms.

Employer: _____

Employee Name: (Last) _____ (First)_____ (MI) _____

Employee Signature_____Date_____

WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employee Name: (Last) _____ (First)_____ (MI) _____

Employer: _____

INDIVIDUALS WAIVING COVERAGE

Name of individual waiving coverage	Reason for waiving coverage	Insurer (Including policyholder name, insurer name and phone number)	Will coverage continue?
Employee:	☐ Other employer group coverage ☐ Individual coverage ☐ Governmental (Medicare, Medicaid, Tricare, etc.) ☐ Other_____		☐ Yes ☐ No
Spouse / Domestic Partner:			
Dependent:			
Dependent:			
Dependent:			

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse/domestic partner) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and 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 (within 60 days if the other coverage was Medicaid or CHIP). 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 for adoption.

I further certify that all information completed on this Waiver of Coverage form is true, correct and complete.

Employee Signature_____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)