



Regence

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

Attn: Utah Membership Department
P.O. Box 1106
Lewiston, ID 83501-1106

For Office Use Only
Group No. _____
Eff. Date _____

NetCare Conversion/Inter-plan Transfer Enrollment Form*

Please follow instructions carefully. Inaccurate, incomplete or illegible applications will be returned.

- MUST BE COMPLETED BY THE APPLICANT**
- PRINT IN BLUE OR BLACK INK**
- COMPLETE ALL APPLICABLE AREAS**
- ATTACH CHECK FOR QUARTERLY OR SUREPAY PREMIUM**
(If SUREPAY, also attach Authorization Form and a copy of your "voided" check.)

PREVIOUS COVERAGE INFORMATION – In the spaces below, please provide information about the policy and coverage from which you are converting.

Name of BlueCross and/or BlueShield Company: _____

Policy Number of Previous Coverage:	State:	BC/BS Telephone No: () _____-
Original Effective Date of Previous Coverage:	Prior Coverage Termination Date:	
Class of Coverage: <input type="checkbox"/> Group <input type="checkbox"/> Individual	If group, employer/company name:	
Were you continuously covered for at least three months prior to your termination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status at time of transfer: <input type="checkbox"/> Single Only <input type="checkbox"/> Two Party <input type="checkbox"/> Family	

Applicant's Name: Last First Initial

Were children under age 26 covered under your previous plan? Yes No

Mailing Address

First Names of Dependents covered under previous plan:

City State ZIP Code

Applicant's Phone Number:
() _____-

Current Family Status: Single Married
 Divorced Widowed

INDIVIDUAL AND FAMILY INFORMATION – REQUIRED FOR ALL PERSONS TO BE COVERED

Family Members Applying for Coverage (Note Child's Last Name if Different)	Check Relationship	Birth Date Month Day Year	Social Security Number
Applicant	Self Male <input type="checkbox"/> Female <input type="checkbox"/>		
Lawful Spouse	Husband <input type="checkbox"/> Wife <input type="checkbox"/>		
Children (under 26, eldest first)	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		
	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		
	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		

1 Are all family members previously covered included on this application? Yes No
If "No" state name of dependent(s) not included and the reason: _____

2 Do you or any listed family members have any other health coverage? Yes No
If "Yes" note below their names, insurance company, and employer if covered through a group: _____

Signature of Applicant: _____ Date: _____

* Inter-plan Transfers use NetCare Conversion plan. See Outline of Coverage for details.