



Regence

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

Regence BlueCross BlueShield of Utah
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Small Employer Application Cover Sheet

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

For use by members/applicants of employer groups with existing Regence coverage.

SECTION 1 - GENERAL INFORMATION (to be completed by the Group Administrator)

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date
Employee Last Name			First Name	Middle Initial

SECTION 2 - PLAN SELECTION

MEDICAL: Innova Engage Regence HSA Healthplan 3.0 BluePoint No Medical
 If your medical plan allows network selection, please select a network.
Network: Preferred FocalPoint Preferred BlueOption Preferred ValueCare Participating
 If your Employer offers multiple medical products with the same name, please provide the following information located at the top of your Benefit Summary.
 Deductible \$ _____ Coinsurance _____ / _____ / _____ % Copay \$ _____

DENTAL: Encore Radiance Expressions No Dental
 If applying for dental only coverage, please complete sections A, B, C, D, and I of the Utah Small Employer Health Insurance Application. Complete section J if waiving coverage.

SECTION 3 - CANCELLATION, COBRA, UTAH MINI-COBRA/STATE CONTINUATION OR NETCARE CONTINUATION

Complete this section if requesting cancellation and/or continuation of coverage.

Cancellation: (select cancellation reason and enter cancellation date below)
 Cancel Employee and All Dependent(s) Cancel All Dependent(s)
 Cancel Dependent(s) - List: _____

Group Administrator signature is required below if cancellation is being requested with an effective date prior to the date this form will be received by Regence BlueCross BlueShield of Utah.

COBRA or Non-COBRA Continuation Enrollment: (Complete sections A, B, and C on the Utah Small Employer Health Insurance Application.)
 COBRA Utah mini-COBRA/State Continuation
 NetCare Continuation-High Deductible Option NetCare Continuation-Low Deductible Option

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event: <input type="checkbox"/> Dependent no longer eligible <input type="checkbox"/> Death <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Military Leave <input type="checkbox"/> Divorce, annulment, or termination of Domestic Partnership <input type="checkbox"/> Reduction of Hours <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Other Medical Coverage <input type="checkbox"/> Other reason _____	Date of Cancellation Event
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This confirms that any employee and/or dependent being cancelled on this form did not have an expectation of coverage after the cancellation effective date and paid no premium after the cancellation effective date.

Group Administrator Signature _____ **Date** _____

SECTION 4 - CURRENT/PRIOR COVERAGE INFORMATION

MEDICARE: If you or any family members listed on this application have Medicare, please complete the following information:

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement <input type="checkbox"/> ESRD			
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement <input type="checkbox"/> ESRD			

