



Regence

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

Regence BlueCross BlueShield of Utah
2890 E. Cottonwood Parkway
PO Box 30270
Salt Lake City, Utah 84130-0270

Small Employer Application Cover Sheet (to be used with the Utah Small Employer Health Insurance Application) For use by members/applicants of employers with existing Regence coverage

SECTION 1 - GENERAL INFORMATION

Employee Name _____

Employer Name _____ Group Number _____

Please check one: Owner Non-Management Salaried Retired
 Management Commissioned Hourly Union

SECTION 2 - PLAN SELECTION INFORMATION

Complete this section if enrolling in Innova, Engage, Activate, or HSA Healthplan 2.0.

Product: Innova Engage Activate Regence HSA Healthplan 2.0 None **Dental:** Encore Radiance Expressions None

If your Employer offers multiple medical or dental products with the same name, please provide the following information located at the top of your Benefit Summary.
 Deductible \$ _____ Coinsurance _____ / _____ / _____ % Copay \$ _____

Complete this section if enrolling in one of our other plan options.

Health Plan Option OR HSA Qualified Plan: <input type="checkbox"/> BlueEssentials SM <input type="checkbox"/> Regence HSA Healthplan/ <input type="checkbox"/> BluePreferred [®] HSA High Deductible Plan <input type="checkbox"/> BlueClassic SM Bank _____	Network Option: <input type="checkbox"/> BlueCross BlueShield <input type="checkbox"/> ValueCare <input type="checkbox"/> HealthWise (not available on Regence HSA Healthplan)	Dental: <input type="checkbox"/> BlueCross BlueShield <input type="checkbox"/> ValueCare	Other: <input type="checkbox"/> Life <input type="checkbox"/> Vision
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SECTION 3 - COBRA, UTAH MINI-COBRA / STATE CONTINUATION, NETCARE CONTINUATION, OR USERRA

Complete this section if requesting continuation of coverage.

COBRA Continuation Utah mini-COBRA/State Continuation (12 months only) NetCare Continuation (12 months only) Military Leave of Absence (USERRA)
 Low Deductible Option
 High Deductible Option

Employer Name (or former employer) _____ Group Number _____

Reason for Election (Qualifying Event):

Employee's termination of employment or reduced working hours Employee's divorce or legal separation
 Voluntary Termination Employee's child's loss of dependent status
 Involuntary Termination Military Training / Active Duty
 Employee's Medicare Entitlement Former Employer's Bankruptcy
 Employee's Death

Date of Qualifying Event (last day of group coverage) _____

SECTION 4 – HEALTH INFORMATION INSTRUCTIONS (Section G of the application)

Complete the Health Statement for ALL eligible family members enrolling AND waiving coverage (family members listed in sections C and D of the application).