



Statewide Schools Retiree Application

Requested Effective Date _____

☐ Retiree Deferral Request

SCHOOL DISTRICT INSTRUCTIONS: Please have the Retiree complete and sign this form, then complete your portion on the back. Have your participating school district or school related group official sign and return the form to Blue Cross of Idaho.

RETIREE INSTRUCTIONS: Please complete the information below and sign and date the back of the form.

Applicant Information (Retiree)				
First Name	Last Name	Middle Initial	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender ☐ Male ☐ Female
Address	City, State, Zip Code	Phone Number		
Social Security Number	Blue Cross of Idaho Identification Number	Blue Cross of Idaho Group Number		
Medicare Beneficiary Number	Date of Retirement	Birthdate		

Dependent Information – Please include the following eligible dependents who are currently covered under my program and will continue to be covered under my Retiree Program. List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (*copy of certification required*).

Dependent Spouse's Name	Spouse's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate

Medical Coverage – Please choose appropriate coverage from the selections below.
Retiree enrollment may be equal to or lesser than active employee enrollment.

UNDER 65				OVER 65						
	Health	Dental (if applicable)	Vision (if applicable)		Retiree Plan with RX	Retiree Plan without RX	Dental Coverage (if applicable)	Vision (if applicable)	Medicare Supplement*	Medicare Advantage**
Employee	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	Employee	☐	☐	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	☐	☐
Spouse	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	Spouse	☐	☐	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	☐	☐
Child	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐							
Child	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐							

* A Medicare Supplement enrollment form is required to enroll in Blue Cross of Idaho's Medicare Supplement plans.
Call 1-888-GO CROSS (1-888-462-7677) toll free to request a form and plan information.

**A Medicare Advantage enrollment form is required to enroll in Blue Cross of Idaho's Medicare Advantage plans.
Call 1-888-492-2583 toll free to request a form and plan information.

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • Mailing Address: P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

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Current/Prior Coverage						
(For Coordination of Benefits, please complete the section below. Use extra paper if necessary).						
Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	

Benefits offered to Retirees **under age 65**, under the Blue Cross of Idaho School Insurance Program, are to be the same benefits offered to active employees. If you had dental coverage through BCI while an active employee, you will be allowed to continue that dental coverage as a Retiree, as long as the group offers that benefit to its employees.

Retirees and/or spouses **over the age of 65** will be enrolled in our Blue Cross of Idaho School Insurance Over 65 Medicare Program and **must** be enrolled in Parts A and B. You are eligible for dental benefits if the participating school district or school related group you retired from participates in BCI's school program and you were enrolled in a dental plan through your participating school district or school related group for **12 months prior to enrolling in this retiree program**.

Please note that Blue Cross of Idaho cannot guarantee billing or payment of all policies selected by PERSI. If for any reason your premiums cannot be paid by PERSI, Blue Cross of Idaho will bill you directly.

RETIREE'S signature: _____ Date: _____

I authorize the Public Employee Retirement System of Idaho (PERSI) and Blue Cross of Idaho to exchange my address and enrollment information for the purpose of administering this plan.

RETIREE'S signature: _____ Date: _____

Sign for Deferment Only

I choose to defer my enrollment in the retiree program as well as my draw on unused sick leave entitlement with PERSI. I understand if I choose not to continue coverage at the time of retirement I may not be able to enroll at a later date. Later enrollment is possible only if your school district or school related group remains with Blue Cross of Idaho and you maintain continuous coverage. If your school district chooses another carrier, you will not be able to enroll in the program.

RETIREE'S signature: _____ Date: _____

TO BE COMPLETED BY THE PARTICIPATING SCHOOL DISTRICT OR SCHOOL RELATED GROUP:
Not necessary for currently enrolled retirees

Coverage paid by the Participating School District or School Related Group through the month of: _____, 20_____

Signature of Participating School District or School Related Group Official

Name of Participating School Group or School Related Group

Group Number

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc. (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic:

ملاحظة: إذا كنت تتحدث العربية اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم هاتف الصم والبكم: 1-800-377-1363).

Bantu:

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 1-800-377-1363).

Chinese:

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 1-800-627-1188 (TTY: 1-800-377-1363)。

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-627-1188 تماس بگیرید. (TTY: 1-800-377-1363)

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS: 1-800-377-1363).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

Japanese:

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。1-800-627-1188 (TTY: 1-800-377-1363) まで、お電話にてご連絡ください。

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018 ext. 3838
Fax: 208-331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. 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, available 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 (TTY). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Nepali:

ध्यान दिनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नेमिती भाषा सहायता सेवाहरु निःशुल्क रुपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटीवीडि: 1-800-377-1363) ।

Romanian:

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croatian:

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 1-800-377-1363).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 1-800-377-1363).