

GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

A nonprofit independent licensee of the BlueCross BlueShield Association													
Instructions on Back. All Dates = mm/dd/yy													
✓ CHECK DESIRED ACTION											(S) COVI	ERED	
☐ Add Subscriber (AA)	Classic Blue Regionwide (KC)			☐ BluePoint 2 (SF)			□ PPO (PN)		0.11	0 150	0.16.0		
Date of Hire/Event / /	D BlueCross (KA)			a block diff 2 (Si)			☐ Excellus BluePPO (BP)		Self, Spouse &	Self & Child(ren)	Self & Spouse	Self	
Coverage Eff Date//				☐ Blue Choice 25 (BZ)			☐ Excellus BlueEPO (BE) ☐ FourFront (EF)		Child(ren)		Гороссо		
☐ Add Dependent (AB)	 □ BCBS and Enhanced Benefits (KC) □ BlueCross Select (KS) 			☐ Blue Choice 30 (BW) ☐ HMOBlue 25 (MZ)			☐ BluePPO/HSA (HF)		(A)	(B)	(C)	(D)	
Date of Event / /	☐ Comprehensive (KD)			☐ HMOBlue 30 (MW)			☐ BluePPO Savings Account Plan (DC)		MEDICAL Q				
Coverage Eff Date//	□ BCBS Comprehensive (CO)												
									DENTAL				
☐ Change Coverage (AC) Coverage Eff Date / / ☐ BCBS Traditional (TR) ☐ BCBS Wraparound (WR)									VISION				
Coverage Eff Date//	- G BCBS Waparu	ilia (VVIX)	1										
		☐ Dental (DE)				Vision (VI)			1				
☐ Transfer to COBRA (AD)	SUBSCRIBER INFORMATION - Must be												
□ (S)ubscriber													
☐ (M) Dependent	Social Securi	Social Security #					/ Sex: 🗆 M 🗆 F Birthdate//						
☐ (D)isabled	Last Name_	Last Name First											
Date of Event / /													
	Street												
Cancel Subscriber (S) City													
Cancel Dependent (M)												5	
Day Phone: LILI-LI E-Mail Address:													
(D)ental	Blue Choice members must select a Medical Center or Primary Care Physician (PCP). Females may select an Ob/Gyn.												
□ (V)ision	Check Medical Center: ((W)ilson (F)olsom (G)reece (P)erinton Current Patient?												
Reason Code (see back)	Primary Prov	Primary Provider (Last) Y										1	
Cancellation Date//	OB/GYN Pro	vider (Last)					(Fir	st)	1	_ DY		1	
FAMILY MEMBER INFORMATIO	N ✓ Check rela	tionship and in	dica	te de	pend	dent name o					elled.		
☐ (S)pouse ☐ (D)ependent	□ Student(T)	Social Security #		Sex				Primary Care Phy		Current par		Y N	
☐ (H)disabled ☐ (F)oster/Gran					(mm/dd/yy)	☐ (W)ilson	Last	Firs	t				
☐ Domestic (P)artner ☐ Other Last Name (if different) Fit			OW	1	, ,	☐ (F)olsom ☐ (G)reece	OB/GYN Physicia	an	Current par	tient?	YO N		
Last Name (if different) Fig.			ΩF	_		(P)erinton	Last	Firs			. —		
☐ (S)pouse ☐ (D)ependent	□ Student(T)	Social Security #		Sex	Т		Medical Center	Primary Care Phy		Current par	tient?	Y N	
(H)disable (F)oster/Grand			- ·		(mm/dd/yy)	☐ (W)ilson	Last	Firs	t				
☐ Domestic (P)artner ☐ Other						, ,	☐ (F)olsom ☐ (G)reece	OB/GYN Physicia	an	Current par	tient? 🗆	Y N	
		_		-		☐ (P)erinton	Last	Firs	t				
☐ (S)pouse ☐ (D)ependent ☐ (H)disabled ☐ (F)oster/Grand	Social Security #		Sex				Primary Care Phy		Current par	tient?	Y N		
☐ (H)disabled ☐ (F)oster/Grandchild Dependent ☐ Domestic (P)artner ☐ Other			102	ΠМ			☐ (W)ilson ☐ (F)olsom	Last	Firs	t ·			
Last Name (if different) First Name				Q F		1 1	☐ (G)reece	OB/GYN Physicia		Current pa	tient? 🗆	Y N	
1	Social Security #	+	Carr	+		(P)erinton	Last .	Firs					
	☐ Student(T) dchild Dependent	Social Security #		Sex			Medical Center ☐ (W)ilson	Primary Care Phy Last	sıcıan/ Firs	Current par	tient?	YU N	
☐ Domestic (P)artner ☐ Other			ΠМ			□ (F)olsom							
Last Name (if different) Fit			ΠF			☐ (G)reece	OB/GYN Physicia	an	Current par	tient?	Y N		
OTHER COVERAGE INFORMA	completed V		nav h	-	ontacted for	(P)erinton	Last		First				
In addition, please provide a co	opy of your "Co	rtificate of Co	vera	ae" f	rom	vour forme	r health insura	nce carrier or	emnlover				
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer. Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?													
☐ Yes ☐ No ✓ Check: ☐ Medical and/or ☐ Dental Are you keeping this coverage? ☐ Yes ☐ No ✓ Check previous insurance company from list below and indicate ID #:													
☐ (B) Excellus BlueCross E	pany from list b	elow and indica	te ID) #:									
□ (B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice. □ (O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name:													
Other Carrier - Indicate Plan Name:													
RELEASE - You must sign and date this form to be eligible for insurance.													
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or													
statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact													
material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and													
the stated value of the claim t	for each such	violation I ha	ve t	horo	ııah	ly read un	discount subjections of the contraction of the cont	ci to a civil pe	ply with the	torma o	f the	anu	
the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.													
Subscriber Signature_								5-4-					
EMPLOYER INFORMATION (Must be of	completed by Groun	Administrator\		-				Date_	D1 "				
Was the employee subject to a waiting period before enrolling in your employer health plan? Yes No													
If yes, what was the start date	// a	nd end date	/ /	, emp	no y e	or ricailii piai	ii u ies u	INO					
	Chk digit Pkg #	Deductible	e Am		$\overline{}$	Employer Na							
Medical			\sqcup	. 0		The state of the s							
Dental			\sqcup	. 0	$\overline{}$	Department #* Employee #*							
Vision				. 0	0	Group Rep Si	ignature/Date						

Instructions for completing the Group Enrollment Form

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the Event Date. Please see your Group Administrator for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you must also check Desired Coverage and Persons covered, and Family Member Information section.

To process a Subscriber or Member Cancellation, please use the Membership Cancellation Worksheet - OR -

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible

PC - Preferred Care

CP - Commercial CB - Cobra Begin Date

CD - Cobra Disabled Date

CE - Cobra End Date SR - Subscriber Request

SD - Subscriber Deceased SB - Spouse's BCBSRA

MC - Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA - Marriage

MB - COBRA Begin Date MR - Subscriber Request

OA - Dependent Over Age

DV - Divorce

DM - Deceased

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

▶ Birthdate

> PCP

> OB/GYN

> Medical Center

DESIRED COVERAGE

All products may not be applicable to your employer group. Please check with your Group Administrator.

PCP Information

Blue Choice members must select a Medical Center OR Primary Care Physician (PCP). Females may select an OB/GYN.

FAMILY MEMBER AND DOCTOR INFORMATION

Use an additional form, if more than four persons.

QUALIFIED GUIDELINES:

A legal spouse (an ex-spouse is not a qualified member as of the divorce date)

- Must be under the dependent age for your employer group
 - Unmarried child, natural, adopted or stepchild
- A full time student (indicate under Relationship)
- Chiefly dependent on you for support
- Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements. Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.

I understand that if I have elected a managed care product that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.

PREFERRED PROVIDER ORGANIZATION (PPO)

I understand that the Preferred Provider Organization (PPO) coverage is comprised of and in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO

EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Administrator. Complete only the coverage section (Medical/Dental/Vision) that is applicable to the employee's request.