



**CONFIDENTIAL**

### Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

#### Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Romulus CSD		<b>Check Desired Action</b>	
Employer Name		<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Association/Chamber Name (if applicable)			
Group Administrator's Signature (required)	Date	Employee Number	Department Number
<b>Medical Information</b>	<b>If enrolling in a Medical plan, who do you need coverage for?</b>	<b>Subscriber Status:</b>	<b>Dental Information</b>
00044316	<input type="checkbox"/> Self Only	<input type="checkbox"/> Actively Working	00055019
Medical Group Number (8 digits)	<input type="checkbox"/> Self & Child(ren)	<input type="checkbox"/> Retired	Dental Group Number
Medical Subgroup Number (4 digits)	<input type="checkbox"/> Self & Spouse	<input type="checkbox"/> Disabled	Dental Subgroup Number
Medical Class Number (e.g. A001)	<input type="checkbox"/> Family	<input type="checkbox"/> Canceled	Dental Class
<b>Medical Plan Selection</b>	<b>Medical Effective Date</b>	<input type="checkbox"/> COBRA	<b>Dental Effective Date</b>
<input type="checkbox"/> (EF) Blue Point 2 \$15/\$15 Rx \$5/\$15/\$30	<input type="checkbox"/> (A1) HealthyBlue Copay \$15 PCP/\$25 Specialist		<b>Dental Plan Selection</b>
<input type="checkbox"/> (A3) HealthyBlue Copay \$30 PCP/\$50 Specialist	<input type="checkbox"/> (BKW) Signature HDHP \$1,500S/\$3,000F w/20% Coinsurance		<input type="checkbox"/> (EDE) Dental Blue Option 3
<input type="checkbox"/> (CDE) Signature HDHP \$5,500S/\$11,000F w/0% Coinsurance			

#### Section 2: Subscriber's Information

Last Name		Birthdate: _____	
First Name		Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Middle Initial	Title (e.g., Jr, Sr, III, etc.)	Gender identity (optional): <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer to self-describe: _____	
Street Address		Social Security Number** _____	
City	State	Date of Hire/Rehire: _____	
Zip Code	Phone	Retirement Date: _____	
E-mail		<input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *	
		Subscriber's Medicare Number (if applicable) _____	
		Medicare Part A Effective Date	Medicare Part B Effective Date
		Primary Care Physician's Last Name	First Name
		Ob/Gyn's Last Name	First Name
		Zip Code	Zip Code

**Section 3: Reason for enrollment or change** To be completed by the Group Administrator Not required for cancellations

**Enrollment Opportunity:**  New Hire     Rehire     Open Enrollment     Medicare eligible

**Special Enrollment Opportunity:**  Newly Eligible Dependent:  Newborn     Marriage     Other \_\_\_\_\_

Change in employment status     A move in or out of the service area

Involuntary loss of coverage     Former dependent regains eligibility    **Date of Event** \_\_\_\_\_

**COBRA Election - Please indicate the reason for COBRA if applicable:**

Left Employment/Retired     Divorce/Legal Separation     Loss of Student Status     Death of Spouse

Disability     Dependent Reached Max Age     Other: \_\_\_\_\_

**Demographic Change:**  Address     Birthdate     Subscriber Name     Dependent Name     Phone Number

**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?**

<b>Subscriber</b>	<b>Cancel Code:</b>	<b>Medical Cancel Date:</b>	<b>Dental Cancel Date:</b>
Cancel Codes: SB02-Left Employment	SB05-Per Group Request	SB06-Subscriber Request (voluntary)	SB07-Deceased    SB09-Enrolled in Error

  

<b>Dependent(s)</b>	<b>Dependent Name:</b>	<b>Cancel Code:</b>	<b>Medical Cancel Date:</b>	<b>Dental Cancel Date:</b>
Cancel Codes: M001-Per Group Request	M004-Enrolled in Error	M008-Moved Out of Area	M013-Ineligible	
M002-Deceased	M005-Divorced	M010-Overage Dependent	M014-YAO Ineligible	
M003-Per Subscriber Request	M007-Per Member Request (voluntary)	M011-No Longer a Student	M040-Mx Same Group	

**Section 5: Information about who you would like coverage for (dependent information)**

Spouse     Dependent Child     Disabled Dependent Child (Separate application form required)

Other \_\_\_\_\_

\_\_\_\_\_  
**Last Name** (if different)    **Title**    **First Name**    **MI**    **Social Security Number \*\***

**Gender assigned at birth:**  Male     Female    **Birthdate** \_\_\_\_\_

**Gender identity (optional):**  Transgender Male     Transgender Female     Non-binary     Prefer not to say     Prefer to self-describe: \_\_\_\_\_

Married?  Yes     No

Medicare Eligible  Yes     No    If yes, indicate reason     Age 65+     Disability     End Stage Renal \*

Part A Effective Date: \_\_\_\_\_    Part B Effective Date: \_\_\_\_\_

Medicare Number (if applicable) \_\_\_\_\_

Primary Care Physician's Last Name    First Name    Zip Code    Ob/Gyn's Last Name    First Name    Zip Code

↓ **Additional Dependent(s)** ↓

Dependent Child     Disabled Dependent Child (Separate application form required)     Other \_\_\_\_\_

\_\_\_\_\_  
**Last Name** (if different)    **Title**    **First Name**    **MI**    **Social Security Number \*\***

**Gender assigned at birth:**  Male     Female    **Birthdate** \_\_\_\_\_

**Gender identity (optional):**  Transgender Male     Transgender Female     Non-binary     Prefer not to say     Prefer to self-describe: \_\_\_\_\_

Married?  Yes     No

Medicare Eligible  Yes     No    If yes, indicate reason     Age 65+     Disability     End Stage Renal \*

Part A Effective Date: \_\_\_\_\_    Part B Effective Date: \_\_\_\_\_

Medicare Number (if applicable) \_\_\_\_\_

Primary Care Physician's Last Name    First Name    Zip Code    Ob/Gyn's Last Name    First Name    Zip Code

Dependent Child    Disabled Dependent Child (Separate application form required)    Other \_\_\_\_\_

\_\_\_\_\_  
**Last Name** (if different)                      **Title**                      **First Name**                      **MI**                      **Social Security Number \*\***

**Gender assigned at birth:**  Male    Female                      **Birthdate** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
**Gender identity (optional):**  Transgender Male    Transgender Female    Non-binary    Prefer not to say    Prefer to self-describe: \_\_\_\_\_  
 Married?  Yes    No

Medicare Eligible  Yes    No                      If yes, indicate reason    Age 65+                       Disability                       End Stage Renal \*  
 Part A Effective Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_                      Part B Effective Date: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Medicare Number (if applicable) \_\_\_\_\_

\_\_\_\_\_  
 Primary Care Physician's Last Name   First Name                      Zip Code                      Ob/Gyn's Last Name                      First Name                      Zip Code

**Note: Use an additional application [or addendum] if more than three dependents need coverage.**

**Section 6: Other coverage information (Required) - You may be contacted for additional information**

Have you or any member of your family been enrolled in other medical or dental coverage?  Yes    No  
 If yes, what type of coverage?  Medical    Dental  
 What is the effective date of the other coverage?  Medical: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_                       Dental: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 What is the name of the other carrier? \_\_\_\_\_  
 Are you keeping the coverage?  Yes    No  
 If no, when will the coverage end?  Medical: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_                       Dental: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Policyholder's name \_\_\_\_\_ ID#(s) \_\_\_\_\_  
 Who did the insurance cover?  Self Only    Self & Spouse/Domestic Partner    Self & Child(ren)    Family

**Section 7: Release - You must sign and date this form to be eligible for health insurance**

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract 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 acknowledgment and agreement on behalf of myself and each other person who accepts 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 hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.  
 Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

**PREFERRED PROVIDER ORGANIZATION (PPO)** I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that 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.

**POINT OF SERVICE (POS)** I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

**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 for each such violation.**

**Subscriber Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please return to P.O. Box 21146 Eagan, MN 55121-0146  
 If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

## Instructions for completing the Group Health Insurance Application/Change Form

### Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

### Section 2: Subscriber's Information

This section should be completed by the Subscriber. \*\*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act. \* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

**Gender and gender identity:** Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

### Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is 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. You may be required to provide documentation of certain events.

### Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

### Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application or addendum if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

\*\*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

\* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

### Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

### Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.