Excellus

PO Box 22999, Rochester, New York 14692

A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM

Instructions on Back. All Dates = mm/dd/yy ☐ Check if name change ☐ Check if new address

✓ CHECK DESIRED ACTION

☐ **Add** Subscriber (AA)
Date of Hire/Event ___/___/___
Coverage Eff Date ___/___/___

☐ **Add** Dependent (AB)
Date of Event ___/___/___
Coverage Eff Date ___/___/___

☐ **Change** Coverage (AC)
Coverage Eff Date ___/___/___

☐ **Transfer** to COBRA (AD)
☐ (S)ubscriber ☐ (D)isabled
☐ (M) Dependent
Date of Event ___/___/___

☐ **Cancel** Subscriber (S)
☐ **Cancel** Dependent (M)
☐ (M)edical
☐ (D)ental
Reason Code _____ (See back)
Cancellation Date ___/___/___
If Reason Code SD or DM, indicate
Date of Death ___/___/___

✓ CHECK DESIRED COVERAGE - Select One Product Option

☐ BluePPO (BP)
☐ BluePPO/HSA (HF)
☐ BluePPO Savings Account Plan (DC)
☐ BluePreferred PPO (PN)
☐ BlueEPO (BE)
☐ BlueEPO Balance (UE)
☐ FourFront (EF)
Blue Healthy Choices:
☐ Fit & Healthy (FH)
☐ Healthy Family (FM)

☐ HMOBlue (MO)
☐ HMOBlue 25 (MZ)
☐ HMOBlue Essential (BL)
☐ HMOBlue Value (HB)
☐ Secure Comp (SC)
☐ Senior Ins. High Option (SH)
☐ BluePoint (BT)
☐ BluePoint 2 (SF)
☐ BCBS Traditional (TR)

☐ BCBS Comprehensive (CO)
☐ Bassett Plus PPO (AS)
☐ Bassett Plus HMO (AT)
☐ HMOBlue NYSCOP (MC)
☐ HMOBlue Preferred NYSCOP (MY)
☐ Traditional RX only (RX)

✓ CHECK DESIRED COVERAGE

☐ Dental (DE) ☐ Dental Blue Classic (DI) ☐ Dental Blue Options (DJ)

✓ CHECK PERSON(S) COVERED

	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
MEDICAL	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐

SUBSCRIBER INFORMATION - Must be completed ✓ Check if Married: ☐ Yes ☐ No Date of marriage: ___/___/___
Social Security # _____-_____-_____ Sex: ☐ M ☐ F Birthdate: ___/___/___
Last Name_____ First_____
Street_____
City_____ State_____ Zip_____
Day Phone: _____ E-mail Address: _____
Do you have Medicare? ☐ Yes ☐ No If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim #: Medicare Part A Eff Date: Medicare Part B Eff Date:
Employment status: ☐ Active ☐ Retired, Provide Retirement date ____/____/____

HMO, Bassett and BluePoint must select a Primary Care Physician (PCP)
Primary Care Physician (Last)_____ (First)_____ Current patient? ☐ Y ☐ N
OB/GYN Physician (Last)_____ (First)_____ Current patient? ☐ Y ☐ N

FAMILY MEMBER INFORMATION ✓ Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other _____
☐ Student(T) ☐ Full-time ☐ Part-time # of Credit Hours:_____
Graduation Date: _____
School Name:
Social Security # _____-_____-_____
Sex: ☐ M ☐ F Birthdate: ___/___/___
Last Name (If different):_____ **First Name:**_____

Primary Care Physician Current patient? ☐ Y ☐ N
Last _____ First _____
OB/GYN Provider Current patient? ☐ Y ☐ N
Last_____ First_____
Enrolled with Medicare? ☐ Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim #:
Medicare Part A Eff Date: Medicare Part B Eff Date:

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other _____
☐ Student(T) ☐ Full-time ☐ Part-time Graduation Date: _____
School Name:
Social Security # _____-_____-_____
Sex: ☐ M ☐ F Birthdate: ___/___/___
Last Name (If different):_____ **First Name:**_____

Primary Care Physician Current patient? ☐ Y ☐ N
Last _____ First _____
OB/GYN Provider Current patient? ☐ Y ☐ N
Last_____ First_____
Enrolled with Medicare? ☐ Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim #:
Medicare Part A Eff Date: Medicare Part B Eff Date:

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other _____
☐ Student(T) ☐ Full-time ☐ Part-time Graduation Date: _____
School Name: _____
Social Security # _____-_____-_____
Sex: ☐ M ☐ F Birthdate: ___/___/___
Last Name (If different):_____ **First Name:**_____

Primary Care Physician Current patient? ☐ Y ☐ N
Last _____ First _____
OB/GYN Provider Current patient? ☐ Y ☐ N
Last_____ First_____
Enrolled with Medicare? ☐ Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim #:
Medicare Part A Eff Date: Medicare Part B Eff Date:

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information. 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 all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug
Are you keeping this coverage? ☐ Yes ☐ No – If No, indicate cancel date ___/___/___
Policyholder's Name_____ Effective Date: ___/___/___ Did this insurance cover ☐ Insured ☐ Insured and Family
✓ Check previous insurance company from list below and indicate ID #:_____
☐ (B) Excellus BlueCross BlueShield
☐ (O) Other - BlueCross BlueShield Plan. Indicate Plan Name: _____
☐ (C) 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 for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back. **Subscriber Signature** _____ **Date**_____

EMPLOYER INFORMATION (Must be completed by Group Representative) Shaded areas are optional.
Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ Yes ☐ No
If yes, what was the start date ___/___/___ and end date ___/___/___

Coverage	Group/Sub Group #	Chk Digit	Pkg #
Medical			
Dental			

Employer Name:
Employee Status ☐ (A) Active: ☐ (A) Full Time ☐ (A) Part-time - # of Hours_____ ☐ (A) Cobra ☐ (A) Termination ☐ (R) Retired
Payroll Location # Employee #
Group Rep Signature **Date**
Return Original to PO Box 22999, Rochester, NY 14692 **GEF040u (Rev 02/06)**

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 Representative 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.

Cancel Request

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 Cancel Subscriber (S) Box
- Check Products to be cancelled (Medical, Dental)
- 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(11)
SD – Subscriber Deceased (05)
SR – Subscriber Request (02)
CB – Cobra Begin Date
CD – Cobra Disabled Date
CE – Cobra End Date (29)
CP – Commercial (09)
SB – Spouse's Excellus BCBS
MC – Medicaid
MX – Medicare (03)

To Cancel a Dependent using the Group Enrollment Form:

- Check Cancel Dependent (M) box
- Check Products to be cancelled (Medical, Dental)
- 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 (25)
OA – Dependent Over Age (20)
DM – Deceased (05)
MS – Ineligible Student (28)
CB – COBRA Begin Date
MR – Subscriber Request (02)
DV – Divorce (25)
MX – Medicare (03)

If the only change is one of the following, please call Customer Service at the telephone number indicated on your identification card. A Group Enrollment Form is not required.
- Address
- Birthdate
- PCP or OB/GYN

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the Medicare Eligible-Group Enrollment Form. If you are disabled, see your Group Representative to determine eligibility for OBRA. If eligible, complete the appropriate form.

FAMILY MEMBER QUALIFIED GUIDELINES: If there are more than three members please use an additional form.

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent and student age for your employer group
  - Unmarried child, natural, adopted or stepchild
  - A full-time student (indicate under Relationship)
  - Chiefly dependent upon you for support
- **Other: The following dependents have additional eligibility requirements.**
  Dependents pending adoption, grandchild dependent*, 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 disabled dependent who is over the dependent age for your employer group. **Please contact Customer Service for the appropriate form.**
  *if supporting documentation is attached.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

EMPLOYER INFORMATION This section to be completed by the Employer Group Representative.
Complete only the coverage section (Medical, Dental) that is applicable to the employee's request.

If you have any questions, please contact Customer Service
Traditional or Comprehensive: 1-800-765-5226
HMO or Point of Service: 1-800-722-7884
PPO: 1-877-381-8659

Membership Inquiries:
1-800-765-5224