Excellus | Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FLASHP

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

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

Williamson CSD

Employer Name

Association/Chamber Name (if applicable)

Check Desired Action

☐ Add ☐ Cancel ☐ Change

Group Administrator's Signature (required) Date

Employee Number

Department Number

Medical Information

00044325

Medical Group Number (8 digits)

Subgroup Class

Who's covered?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse
☐Family

Medical Effective Date

Subscriber Status:

☐Actively Working
☐Retired
☐Disabled
☐Canceled
☐COBRA

Dental Information

00055026

Dental Group Number

Subgroup Class

Who's covered?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse
☐Family

Dental Effective Date

Medical Plan Selection

☐ (ED) Blue Point 2 $5/$10 Rx $10/$25/$40

☐ (ET) Blue Point 2 $20/$20 Rx $10/$25/$40

☐ (A1) HealthyBlue Copay $15 PCP/$25 Specialist

☐ (A2) HealthyBlue Copay $25 PCP/$40 Specialist

☐ (A3) HealthyBlue Copay $30 PCP/$50 Specialist

☐ (A5) HealthyBlue Copay $40 PCP/$60 Specialist

☐ (BKW) Signature HDHP $1,800S/$3,600F w/20% Coinsurance

☐ (CDE) Signature HDHP $5,500S/$11,000F w/0% Coinsurance

Dental Plan Selection

☐ (EDC) Dental Blue Option 1 modified

Section 2: Subscriber's Information

Last Name

First Name

Middle Initial **Title (e.g., Jr, Sr, III, etc.)**

Street Address

City **State**

Zip Code **Phone**

Birth Date

Gender: ☐Female ☐Male ☐Gender X

Social Security Number**

Date of Hire/Rehire

Retirement Date

☐Age 65+ ☐Disability
☐End Stage Renal *

Subscriber's Medicare Number (if applicable)

Medicare Part A Effective Date

Medicare Part B Effective Date

You must fill out the following section: Would you like to be added to the Donate Life Registry? ☐Yes ☐Skip this question

Primary Care Physician's Last Name First Name Zip Code

Ob/Gyn's Last Name First Name Zip Code

Subscriber's Last Name: _____

Section 3: Reason for enrollment or change

To be completed by the Group Administrator Not required for cancelations

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?

Subscriber

Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Coverage ends at 11:59 p.m. on date indicated

Cancel Codes:

SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*

SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits

SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

* = Not eligible for COBRA

Dependent(s)

Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

* = Not eligible for COBRA

Cancel Codes:

M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent

M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage

M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

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

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

☐Other_____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: ____ , ____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐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 ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: ____ , ____ , _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐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

Subscriber's Last Name: _____

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

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

Gender: ☐Female ☐Male ☐Gender X **Birthdate** _____ , _____ , _____

Is dependent a full-time student over age 19? ☐Yes ☐No Married? ☐No ☐Yes ___ , ___ , ____ Expected Graduation Date: _____ , _____ , _____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐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 plan, you agree to enroll in the dental plan offered to you by your employer.

HEALTH MAINTENANCE ORGANIZATION (HMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. **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, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

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.

Health Equity: Health care should meet the needs of everyone—no matter who you are, where you live, or who you love. To learn more about health equity and view our privacy policy, visit ExcellusBCBS.com/HealthEquity.

Donate Life Registry: By checking 'Yes' and signing this application, you are consenting to enroll in the New York State Donate Life Registry (Registry). To modify your gift or withdraw from the Registry go to: donatelife.ny.gov or call the Registry at 1-866-NY-DONOR.

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.