

SCHOOL:										REVISION DATE: 8/20/26									
SCHOOL DISTRICT NAME:																			
CIRCLE SUBSCRIBER STATUS: ACTIVE RETIREE YOUNG ADULT UNTIL AGE 29																			
CIRCLE TYPE OF MEDICAL COVERAGE: POS SINGLE OR FAMILY SINGLE OVER 65 FAMILY OVER 65 1-OVER-1-UNDER PPO SINGLE OR FAMILY SINGLE OVER 65 FAMILY OVER 65 1-OVER-1-UNDER *FOR PPO, CHOOSE INDEMNITY 998 \$50/\$100 \$100/\$200 \$250/\$500 HYBRID SINGLE OR FAMILY HIGH DEDUCTIBLE SINGLE OR FAMILY																			
CIRCLE Rx COPAY: \$0 \$2 \$10 \$7/4/1 \$10/2 \$10/4/1 \$2/20/35 (FORMULARY PLAN) Other :\$1 \$8/4/1 \$10/4 \$10/7/4 80% MAJOR																			
										CIRCLE REASON FOR ENROLLMENT/CHANGE COBRA ELIGIBLE EVENTS : NEW HIRE / REHIRE LOSS OF COVERAGE ELIGIBILITY CHANGE OPEN ENROLLMENT RETIREMENT(UNDER AGE 65) NOT COBRA ELIGIBLE EVENTS: RETIREMENT/COVERAGE UNCHANGING RETIREMENT(AGE 65 AND OVER) MEMBER CHANGES: ADDRESS/PHONE NUMBER LAST NAME ADD DEPENDENT* COBRA ELIGIBLE EVENTS: NEWBORN MARRIAGE ADOPTION NOT COBRA ELIGIBLE EVENTS: LOSS OF COVERAGE OPEN ENROLLMENT DEPENDENT CHANGE* LAST NAME DROP DEPENDENT* COBRA ELIGIBLE EVENTS: DIVORCE LEGAL SEPARATION CEASE BY AGE RETIREMENT OF SUBSCRIBER NOT COBRA ELIGIBLE EVENTS: OPEN ENROLLMENT OBTAINING OWN COVERAGE DECEASED									
DISTRICT SIGNATURE										DATE					EFFECTIVE DATE OF APPLICATION/CHANGE				

FAX TO : 716-376-8419 OR SCAN/EMAIL TO: Marcia_Wright@caboces.org After filled out by both District and subscriber.

SUBSCRIBER INFORMATION							
SOCIAL SECURITY NUMBER:			DATE OF BIRTH:		TELEPHONE #:		CIRCLE GENDER M OR F
LAST NAME:			FIRST NAME:		M.I.		
MAILING ADDRESS:			CITY:		STATE:		ZIP CODE:
CIRCLE MARITAL STATUS: SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED MARITAL STATUS EVENT DATE:							
PCP INFORMATION WILL BE REQUESTED BY LETTER FROM BCBS FOR NEW ENROLLEES. PCP CHANGES BY CURRENT MEMBERS--NOTIFY BCBS CUSTOMER SERVICE 1-888-839-5169 OR GO ONLINE AT BCBSWNY.COM							

DEPENDENT INFORMATION								
		DEPENDENT LAST NAME	FIRST NAME	M. I.	RELATIONSHIP	GENDER	SOCIAL SECURITY #	BIRTH DATE
☐	REMOVE							
☐	REMOVE							
☐	REMOVE							
☐	REMOVE							

*DO YOU OR ANY OF YOUR DEPENDENTS HAVE ADDITIONAL GROUP HEALTH INSURANCE? _____ IF SO, PLEASE LIST NAME OF FAMILY MEMBERS: _____

MEDICARE INFORMATION: PLEASE LIST ANY FAMILY MEMBERS WHO CURRENTLY HAVE MEDICARE COVERAGE			
NAME:		NAME:	
MEDICARE PART A EFFECTIVE DATE:	PART B EFFECTIVE DATE:	MEDICARE PART A EFFECTIVE DATE:	PART B EFFECTIVE DATE:

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 five thousand dollars and the stated value of the claim for each such violation.

Subscriber's signature _____ Date _____