Excellus

P.O. Box 22999, Rochester, NY 14692

A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

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

✓ 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 ___ / ___ / ___

✓ CHECK DESIRED MEDICAL/DENTAL/VISION COVERAGE

Classic Blue
- ☐ Regionwide (KC)
- ☐ BlueCross (KA)
- ☐ BlueCross BlueShield (KB)
- ☐ BCBS and Enhanced Benefits (KC)
- ☐ BlueCross Select (KS)
- ☐ Comprehensive (KD)
- ☐ BCBS Comprehensive (CO)
- ☐ Comprehensive Plus (CP)
- ☐ BCBS Traditional (TR)
- ☐ BCBS Wraparound (WR)

- ☐ BluePoint 2 (SF)
- ☐ Blue Choice 25 (BZ)
- ☐ Blue Choice 30 (BW)
- ☐ HMOBlue 25 (MZ)
- ☐ HMOBlue 30 (MW)

- ☐ PPO (PN)
- ☐ Excellus BluePPO (BP)
- ☐ Excellus BlueEPO (BE)
- ☐ FourFront (EF)
- ☐ BluePPO/HSA (HF)
- ☐ BluePPO Savings Account Plan (DC)

❑ Dental **(DE)**____ ❑ Vision **(VI)** ____

✓ CHECK PERSON(S) COVERED

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

☐ **Transfer** to COBRA (AD)
- ☐ (S)ubscriber
- ☐ (M) Dependent
- ☐ (D)isabled

Date of Event ___ / ___ / ___

☐ **Cancel** Subscriber (S)
☐ **Cancel** Dependent (M)
- ☐ (M)edical
- ☐ (D)ental
- ☐ (V)ision

Reason Code (see back)_____
Cancellation Date ___ / ___ / ___

SUBSCRIBER INFORMATION - Must be completed

Social Security # _____ _____ _____ Sex: ☐ M ☐ F Birthdate ___ / ___ / ___

Last Name_____ First_____

Street_____

City_____ State_____ Zip_____

Day Phone: |_|_|_|-|_|_|_|-|_|_|_|_| E-Mail Address:_____

Blue Choice members must select a Medical Center or Primary Care Physician (PCP). Females may select an Ob/Gyn.

Check Medical Center: ☐ (W)ilson ☐ (F)olsom ☐ (G)reece ☐ (P)erinton Current Patient?

Primary Provider (Last)_____ (First)_____ ☐ Y ☐ N

OB/GYN Provider (Last)_____ (First)_____ ☐ Y ☐ N

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

Relationship	Social Security #	Sex	Birthdate (mm/dd/yy)	Medical Center	Primary Care Physician	OB/GYN Physician
☐ (S)pouse ☐ (D)ependent ☐ Student(T) ☐ (H)disabled ☐ (F)oster/Grandchild Dependent ☐ Domestic (P)artner ☐ Other_____ *Last Name (if different)* *First Name*		☐ M ☐ F	___/___/___	☐ (W)ilson ☐ (F)olsom ☐ (G)reece ☐ (P)erinton	Last First Current patient? ☐ Y ☐ N	Last First Current patient? ☐ Y ☐ N
☐ (S)pouse ☐ (D)ependent ☐ Student(T) ☐ (H)disable ☐ (F)oster/Grandchild Dependent ☐ Domestic (P)artner ☐ Other_____ *Last Name (if different)* *First Name*		☐ M ☐ F	___/___/___	☐ (W)ilson ☐ (F)olsom ☐ (G)reece ☐ (P)erinton	Last First Current patient? ☐ Y ☐ N	Last First Current patient? ☐ Y ☐ N
☐ (S)pouse ☐ (D)ependent ☐ Student(T) ☐ (H)disabled ☐ (F)oster/Grandchild Dependent ☐ Domestic (P)artner ☐ Other_____ *Last Name (if different)* *First Name*		☐ M ☐ F	___/___/___	☐ (W)ilson ☐ (F)olsom ☐ (G)reece ☐ (P)erinton	Last First Current patient? ☐ Y ☐ N	Last First Current patient? ☐ Y ☐ N
☐ (S)pouse ☐ (D)ependent ☐ Student(T) ☐ (H)disabled ☐ (F)oster/Grandchild Dependent ☐ Domestic (P)artner ☐ Other_____ *Last Name (if different)* *First Name*		☐ M ☐ F	___/___/___	☐ (W)ilson ☐ (F)olsom ☐ (G)reece ☐ (P)erinton	Last First Current patient? ☐ Y ☐ N	Last First Current patient? ☐ Y ☐ N

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: ☐ Medical and/or ☐ Dental Are you keeping this coverage? ☐ Yes ☐ No
✓ Check previous insurance company from list below and indicate ID #:_____
☐ (B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice.
☐ (O) Other - BlueCross BlueShield Plan (outside of Rochester). 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 Administrator) *Deductible Amt., Dept. # and Employee # is 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 #	Deductible Amount*	Employer Name
Medical				. 0 0	Employee Status ❑ (A)Active ❑ (A)COBRA ❑ (A)Cancellation ❑ (R)etired
Dental				. 0 0	Department #* Employee #*
Vision				. 0 0	Group Rep Signature/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.

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 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
OA - Dependent Over Age
DM - Deceased
MB - COBRA Begin Date
MR - Subscriber Request
DV - Divorce

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.

- Address
- 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.
- **BLUE CHOICE**
  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.

If you have any questions, please contact Customer Service at:
Excellus BlueCross BlueShield, Rochester Region (585) 325-3630 or 1-800-847-1200
Blue Choice Member Services (585) 454-4810 or 1-800-462-0108