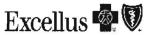
Excellus Low Option Rates T Individual \$31.86/mo; Family \$83.67/mo

Excellus High Option Rate Individual \$39.87/mo; Family \$104.70/mo A porprofit independent licensee of the BlueCross BlueShield Association A porprofit independent licensee of the BlueCross BlueShield Association High Option	DO NOT USE - FOR INTERNAL PURPOSES ONLY HIOS ID#EC	
P.O. Sox 22999, Rochester, NY 14692 Instructions on last page. All Dates = mm/dd/yy GROUP ENROLLMENT FORM	PLEASE PRINT CLEARLY	
1 - Group Employer Information	TEASET WIN SEEMEN	
This section should be completed by the Group Benefits Administrator. This application cannot be processed without this information and a signature.		
Please use blue or black ink, print one character per box Subscriber Sta	atus:	
Group # Class# Active	Retired COBRA Cancelled	
Please indicate	e reason for COBRA:	
Employer Name Left Emp	loy/Retirement Death of Spouse	
Divorce/L	egal Separation Dependent Reached Max Age	
	Student Status Other	
Association of them (if approache)		
Effective I	Date COBRA Effective Date	
Group Administrator Signature/Date		
X Hire/Reh	ire Date Retired Effective Date	
Dental Group # Subgroup #		
Was the employee subject to a waiting period before enrolling in your employer health plan?	No Yes	
If yes, what was the start date: and end date and end date		
2 - Subscriber Plan Selection Department # Employ	ee#	
Please use blue or black ink, print one character per box. Check applicable plan(s).		
BCBS & Enhanced Benefits (I4)	k coverage type and person(s) to be covered:	
	☐ single ☐ sub & spouse☐ sub & dependent(s) ☐ family ☐ single ☐ sub & spouse☐ sub & dependent(s) ☐ family	
Story (1909 Family Deductible (IH) Option C (P3) Option I (PF) Option L-2 (PV)		
Stop Single 3-500 Single 3-500 Family Deductible (II) □ Option C-2 (P4) □ Option C-2 (P4) □ Option C-3 (P5) □ Option Split (AVF) □ Op		
Option C-4 (PU)	C	
□ \$5 Copay (FA) □ Option E (P8) □ Option J (PJ) □ Option M-4 (BQ2) □ Option B (C	D2) Option J (QA)	
\$15 Copay (FC)		
Option D (C	Q4) Option L (QC)	
3 - Reason for Enrollment/Change	9) Option L Split (AWF)	
Subscriber, please indicate the reason for this enrollment or change.		
New Hire COBRA Retirement Loss of Coverage	Domestic Partner	
Open Enrollment Address/Phone Number Last Name Age 65+	Remove Dependent Change in Student Status	
Medicare Eligible / Please indicate reason for Medicare eligibility: Newborn	Disability End Stage Renal Disease	
Add Dependent / Please indicate reason for adding dependent: Adoption	Marriage Marital Status Change	
4 - Subscriber Information		
Please complete both sides of this application. The subscriber signature is required in order to process the application.		
Subscriber's Last Name Subscriber's Fi	rst Name	
Middle Initial Title F mail Address		
Middle Initial Title E-mail Address		
Mailing Address	Apt or Suite	
City State	Zip	

Date of Birth Gender Social Security Number		
Marital Status: Single Married Legally Separated Divorced/ Marital Status Event Date		
Medicare Number (if applicable) Part A Effective Date Part B Effective Date		
If Medicare eligible due to ESRD please check type of dialysis: Self administered Facilitated Date started		
5 - Other Coverage Information Have you ever been a member of Excellus BlueCross BlueShield? Yes No	-	
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? No Year	es	
/Dental? No Yes	Co	
If answering "Yes", are you keeping the additional health or dental coverage? Health? No Yes / Dental? No Yes		
Who did the other plan cover? Self Spouse Children		
Other insurance carrier name: Other insurance name of policyholder:		
Policy ID Number: Effective Date Termination Date		
6 - Cancellation Information Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).		
Subscriber Medical /Reason Date	- 4	
Dental /Reason Date		
Dependent (list each dependent in section 7)		
Medical / Reason Date Date		
Dental / Reason Date		
7 Dependent Information		
7 - Dependent Information		
Please provide all information for each person to be covered.		
Please provide all information for each person to be covered.		
Please provide all information for each person to be covered. Subscriber's Last Name Subscriber's First Name		
Please provide all information for each person to be covered. Subscriber's Last Name Subscriber's First Name		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Please provide all information for each person to be covered. Subscriber's First Name Subscriber's First Name Spouse/Domestic Partner First Name M.I. Are you enrolling as a Domestic Partner? Yes No		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Subscriber's First Name Are you enrolling as a Domestic Partner?		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Please provide all information for each person to be covered. Subscriber's First Name Subscriber's First Name Spouse/Domestic Partner First Name M.I. Are you enrolling as a Domestic Partner? Yes No		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Please provide all information for each person to be covered. Subscriber's First Name Subscriber's First Name Spouse/Domestic Partner First Name M.I. Are you enrolling as a Domestic Partner? Yes No		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Part A Effective Date Part B Effective Date		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Part A Effective Date Part B Effective Date		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Male Date of Birth Social Security Number Female Part A Effective Date Part A Effective Date Dependent's Last Name Dependent's Last Name Dependent's First Name M.I. Dependent's Last Name Dependent's First Name M.I. Dependent's First Name M.I.		
Subscriber's Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? Female Yes No Medicare Number (if applicable) Part A Effective Date Part B Effective Date Dependent's First Name M.I. Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female (See last page for additional information) No Is Dependent a full time student? No Yes If yes, please indicate college/university name:		
Subscriber's Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? Part A Effective Date Part B Effective Date Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female (See last page for additional information) No		
Subscriber's Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name Male Date of Birth Social Security Number Part A Effective Date Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye See last page for additional information) No Is Dependent a full time student? No Yes If yes, please indicate college/university name: College/University Name Expected Graduation Date Credit hours		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? Female Part A Effective Date Part B Effective Date Dependent's Last Name Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female Social Security Number Female Subscriber Signature Subscriber signature required. You must sign and date this form to be eligible for insurance.		
Subscriber's Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Part A Effective Date Part A Effective Date Part B Effective Date Part B Effective Date Spouse/Domestic Partner? Female Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Social Security Number Spouse/Domestic Partner First Name M.I. Dependent's Last Name Spouse/Domestic Partner First Name M.I. Social Security Number Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Part B Effective Date Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Part B Effective Date Part B Effective Date Spouse/Domestic Partner First Name No. Medicare Number (if applicable) Part A Effective Date Part B E		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name Male Date of Birth Social Security Number Female Dependent's Last Name Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Female Spouse/Domestic Partner First Name M.I. Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female Spouse/Domestic Partner First Name M.I. Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female Spouse/Domestic Partner First Name M.I. Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female Spouse/Domestic Partner First Name M.I. Dependent's First Name M.I. Dependent's First Name M.I. Spouse/Domestic Partner First Name M.I. Dependent's First Name M.I. Spouse/Domestic Partner First Name M.I.		
Subscriber's Last Name Subscriber's First Name Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I. Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? Female Part A Effective Date Part B Effective Date Dependent's Last Name Dependent's First Name M.I. Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Ye Female (See last page for additional information) No Is Dependent a full time student? No Yes If yes, please indicate college/university name: College/University Name Expected Graduation Date Credit hours 8 - Release/Signature Subscriber signature required. 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		



GROUP ENROLLMENT FORM

A nonprofit independent licensee of the BlueCross BlueShield Association P.O. Box 22999, Rochester, NY 14692

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 – Additional Dependents		
Please provide all information for each person to be covered.		
Subscriber's Last Name Subscriber's First Name		
Dependent's Last Name Dependent's First Name M.I.		
Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes		
Female See last page for additional information) No		
Is Dependent a full time student? No Yes If yes, please indicate college/university name:		
College/University Name Expected Graduation Date Credit hours		
Expected Gladulation Date Credit flours		
Dependent's Last Name Dependent's First Name M.I.		
Dependent's Last Name Dependent's First Name M.I.		
Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes		
Female (See last page for additional information) No		
Is Dependent a full time student? No Yes If yes, please indicate college/university name:		
College/University Name Expected Graduation Date Credit hours		
Dependent's Last Name Dependent's First Name M.I.		
Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes		
Female (See last page for additional information) No		
Is Dependent a full time student? No Yes If yes, please indicate college/university name:		
College/University Name Expected Graduation Date Credit hours		
Dependent's Last Name Dependent's First Name M.I.		
Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes		
Female		
Is Dependent a full time student? No Yes If yes, please indicate college/university name:		
College/University Name Expected Graduation Date Credit hours		

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. 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/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

Transfer to HMO Transfer to POS

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible Commercial COBRA Begin Date COBRA Handicapped/Disabled Date Transfer to Traditional COBRA End Date Subscriber Request Subscriber Deceased Spouse's Insurance Medicaid Medicare

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- > check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law Dependent Over Age Deceased Ineligible Student COBRA Begin Date Subscriber Request Divorce

Divorce Medicare

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

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than seven dependents please use an additional form. **QUALIFIED GUIDELINES:**

- > A legal spouse (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group:
 - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

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.
- 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 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.
- (Applies to Dental Only) The certificate or contract for which application is being made may impose a waiting period on member(s) 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.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative.

Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact your Group Administrator/Representative Or, visit us at:

www.excellusbcbs.com