Excellus

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#______________________________

EC___________________________________

P.O. Box 22999, Rochester, NY 14692

A nonprofit independent licensee of the BlueCross BlueShield Association

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

Tompkins County
GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY

1 – Group Employer Information

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

Group #
00036755

Subgroup # ☐☐☐☐ Class# ☐☐☐☐

Employer Name
Tompkins County

Association/Chamber Name (if applicable)

Group Administrator Signature/Date

X

Subscriber Status:

☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:

☐ Left Employ/Retirement ☐ Death of Spouse
☐ Divorce/Legal Separation ☐ Dependent Reached Max Age
☐ Other ___________________

Effective Date ☐☐☐☐☐☐ COBRA Effective Date ☐☐☐☐☐☐

Hire/Rehire Date ☐☐☐☐☐☐ Retired Effective Date ☐☐☐☐☐☐

2 – Subscriber Plan Selection

Department # ☐☐☐☐☐☐☐☐ Employee # ☐☐☐☐☐☐☐☐☐☐

Please use blue or black ink, print one character per box. Check applicable plan(s).

☐ Classic Blue (BFZ)
☐ Classic Blue (BGG)
☐ Classic Blue (BFI)
☐ Classic Blue (BFK)
☐ Classic Blue (BFL)

☐ SB (DAA) Platinum

☐ PPO $10 (BET)
☐ PPO $10 (BEV)
☐ PPO $10 (BEW)

☐ COMP- Value Plan (BEL)

Please check coverage type and person(s) to be covered:

☐ Medical ☐ single ☐ ☐ family

3 – Reason for Enrollment/Change

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 First Name

Middle Initial | Title | E-mail Address

Mailing Address | Apt or Suite

City | State | Zip

Work Phone Number ☐☐☐-☐☐☐-☐☐☐☐ / Home Phone Number ☐☐☐-☐☐☐-☐☐☐☐ / Cell Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth ☐☐☐☐☐☐ | Gender ☐ M ☐ F | Social Security Number ☐☐☐-☐☐-☐☐☐☐

SF FAP *Return Original to Excellus BlueCross BlueShield, at above address – Copy: Employer Group: Greater Tompkins Municipality*

9/13

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 ☐ Yes

If answering "Yes", are you keeping the additional health coverage? Health? ☐ 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 ☐☐☐☐☐☐

Dependent (list each dependent in section 7)

☐ Medical / Reason _____ Date ☐☐☐☐☐☐

7 – Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Spouse[/Domestic Partner] Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Spouse[/Domestic Partner] First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M.I. ☐

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐ Are you enrolling as a Domestic Partner? ☐ Yes ☐ No

Medicare Number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐ Part A Effective Date ☐☐☐☐☐☐ Part B Effective Date ☐☐☐☐☐☐

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐]

Dependent's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Dependent's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M.I. ☐

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐ Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

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 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**_____

Excellus

Tompkins County
GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
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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

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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

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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

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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

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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

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

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
Transfer to HMO
Transfer to POS
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
COBRA Begin Date
Subscriber Request
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 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.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:
1-800-499-1275 **Or, visit us at:**
www.excellusbcbs.com

Tompkins County
Human Resources
125 E. Court St.
Ithaca, NY 14850
(607) 274-5526

Dependent Eligibility Verification Form

CSEA WC, CSEA BC, Corrections, Confidential, Management, Public Library Employees, all County Retirees (County, TC3, Library)

Complete this form if you are enrolling any dependents (spouse, domestic partner, children), and for each dependent listed please attach the required documentation to confirm eligibility of your dependents. Use additional forms if needed.

SUBSCRIBER:

Employee Name *(Last, First, MI)*: _____

Employee SSN: _____ Employee DOB: _____ Employee ID #: _____

Employee Mailing Address:

_____

Street City State Zip Code

Employee Home Address:

_____

Street City State Zip Code

Phone Number: _____

Marital Status (circle one): Single / Married / Domestic Partnership / Legally Separated

If Married, Date of Marriage: _____

SPOUSE OR DOMESTIC PARTNER:

Spouse/DP Name *(Last, First, MI)*: _____

Spouse/DP Social Security #:_____ Spouse/DP Date of Birth: _____

Spouse/DP Address:

_____

Street City State Zip Code

Phone Number: _____

DEPENDENT 1:

Dependent Name *(Last, First, MI)*: _____

Dependent Social Security #:_____ Dependent Date of Birth: _____

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

Is this dependent considered disabled? ***Yes or No*** (circle one) Temporary/Permanent? _____

Date of Dependent's Disability: _____

DEPENDENT 2:

Dependent Name *(Last, First, MI)*: _____

Dependent Social Security #:_____ Dependent Date of Birth: _____

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

Is this dependent considered disabled? ***Yes or No*** (circle one) Temporary/Permanent? _____

Date of Dependent's Disability: _____

DEPENDENT 3:

Dependent Name *(Last, First, MI)*: _____

Dependent Social Security #:_____ Dependent Date of Birth: _____

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

Is this dependent considered disabled? ***Yes or No*** (circle one) Temporary/Permanent? _____

Date of Dependent's Disability: _____

DEPENDENT4:

Dependent Name *(Last, First, MI)*: _____

Dependent Social Security #:_____ Dependent Date of Birth: _____

Relationship to Employee: _____

Dependent Address:

_____

Street City State Zip Code

Is this dependent considered disabled? ***Yes or No*** (circle one) Temporary/Permanent? _____

Date of Dependent's Disability: _____

Are you or any dependents covered under any other health insurance that will be kept while enrolled in coverage through Tompkins County, including Medicaid or Medicare? *Yes or No* (Circle One) If yes, please provide:

Name (Employee and/or Dependent)	***Insurance Carrier***	***Group #***	***Member ID #***	***Effective Date***

PRESENTATION OF A FALSE STATEMENT IN SUPPORT OF AN APPLICATION FOR HEALTH INSURANCE COVERAGE OR A CLAIM FOR PAYMENT IS PROHIBITED BY SECTION 176.05 OF THE PENAL LAW.

_____ _____

Signature ***Date***

The following is a list of required documentation to be provided with your completed information for each family member to be considered for benefit eligibility:

Spouse – Required Documentation

Government Issued Marriage Certificate (If Married in the Last 12 Months)

OR

Government Issued Marriage Certificate AND Most Recent Federal or State Tax Return (If Married Longer Than 12 Months):

- Your most recent filed Tax Return showing "married filing jointly" OR "married filing separately". Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status (or vice versa).
- Only submit page 1 of the return. This could include the 1040 form, e-File Confirmation Page, Tax Preparer's Summary, Federal Return Recap, or Tele-File.
- Mark out all financial information and the first five digits of all Social Security numbers.
- Your documents will be copied and originals returned to you.

Domestic Partner – Required Documentation

Government Issued Domestic Partner Registry Certificate (If Issued in the Last 12 Months)

OR

Government Issued Domestic Partner Registry Certificate AND Proof of Co-habitation/Residency (If Issued More Than 12 Months Ago)

Submit BOTH your Domestic Partner Registry Certificate and proof of co-habitation/residency. Both the enrollee's and domestic partner's name must be listed on the documentation of joint ownership or residency and contain recent dates (within the last 6 months). Examples include copy of:

- Mortgage Statement
- Homeowners/Renters Insurance Policy
- Property Tax Document
- Rental/Lease Agreement

You may need to also file a Tompkins County Domestic Partner Affidavit for Tax Implications on Employee Benefit Plans if your Domestic Partner is considered your dependent under Internal Revenue Code Section 152. Please see Domestic Partner Benefit summary for details on tax implications regarding Domestic Partnerships and Benefits.

Child (Natural, Adopted, Stepchild) – Required Documentation
Proof of relationship is required for all children to be considered for benefits.

Biological Children < Age 26

- Copy of government issued Birth Certificate, containing the child's name, birth date and parents' names.
- A non-government issued Birth Certificate including the child's name, date of birth, and parents' names may be used if the child is under 3 months of age.

Step-Children < Age 26
The step-children of the subscriber are eligible for coverage as of the date the subscriber marries the child's parent. Please provide:

- A copy of the child's Birth Certificate and a copy of the marriage license to establish the relationship to the subscriber as step-parent.

Adopted Children < Age 26
Adoption Placement Agreement including the child's date of birth or Petition of Adoption including the child's date of birth. This could be an Adoption Certificate, adoption papers, or other official document issued by the U.S. Government, including the child's date of birth.

Guardianship < Age 26
A child for whom the subscriber is the legal guardian and who is chiefly dependent upon the subscriber for support is eligible. Custody alone is not sufficient. A court must specifically confer legal guardianship. Please provide the following:

- A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey legal guardianship.
- Proof of financial dependency.

Adult Child >26 and <30 Young Adult Option (New York State Mandate-7/1/2010)
Young adult Option Outline: Under the age of 30, dependent child, residency with parent not required, NYS residency required, cannot be married, student status is not required. Proof of dependent residency required – one of the following in the dependent's name:

- Driver's License
- Tax Return
- Utility/Telephone Bill
- Lease/Rental Agreement

Disabled Adult Child
A child who is incapable of self-sustaining employment may be eligible to continue coverage beyond the age where coverage would otherwise terminate in the case of mental illness, developmental disability as defined by NYS Mental Hygiene Law, and/or physical disability. The child must also meet the following conditions:

- The condition occurred before the dependent reached the maximum age under the certificate
- The child was covered at the time he or she would have otherwise reached the maximum age under the certificate
- The condition continues to exist
- The child remains unmarried
- The child remains dependent upon the subscriber for support

A Medical Director from Excellus BlueCross BlueShield reviews all applications for coverage for a disabled dependent. The Medical Director will determine whether the condition is permanent or temporary. If the condition is temporary, Excellus will periodically request the recertification of the dependent's eligibility, through the submission of a new disabled dependent form.

Appeal Process
When the County determines there is insufficient documentation provided to support the relationship between a spouse/dependent on the employee's health insurance employees will be given written notice in advance of the effective date of removal, and the reasons the documentation provided was insufficient.

To appeal the determination:

Step 1: The employee may submit a written appeal to the County Attorney, with a copy to the Union President within ten (10) calendar days of the date of the notice of removal. The County Attorney will respond writing to member and Union of his or her determination within ten (10) days of receipt of the written appeal.

Step 2: If the issue is not resolved to the employee and Union's satisfaction the employees whose dependents, including spouse, who are found to be ineligible for coverage under the employer's health insurance plan may then file a grievance within ten (10) days under Step 2 of the grievance procedure of the Collective Bargaining Agreement. At such Step 2 meeting each party shall be entitled to bring in additional persons who are qualified to review such documentation. Step 2 shall consist solely of a review of all documents submitted by the employee including but not limited to any written explanation or affidavits addressing reason why the employee asserts the dependent is eligible. The dependents of employees who submit a timely appeal of ineligibility determination, shall not have their coverage terminated while the Step 2 appeal is pending.

Step 3: If the decision in Step 2 is unacceptable to the aggrieved party, the Association may submit the matter to arbitration by submitting a request for a hearing to arbitration, with a copy to the Commissioner of Personnel within ten (10) days of the Step 2 decision.

Both parties may strike a panel member at any time and the parties may agree upon a replacement arbitrator. There shall be no more than three (3) arbitrators on the panel. If at least one panel member does not remain, arbitrations shall be conducted under the rules of the Public Employment Relations Board until such time as the parties can agree on a panel of members. The issue before the arbitrator shall be limited solely to determining if the documentation supplied was sufficient to document the relationship as required by the Tompkins County Health Insurance Consortium. The arbitrator's decision shall be binding. The cost of such Hearing Officer shall be shared equally between the parties.