Excellus
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FOR INTERNAL USE ONLY
HIOS ID# _____
EC _____

Commercial Group Health Insurance Application/Change Form

CONFIDENTIAL

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

Tompkins County — Employer Name
N/A — Association/Chamber Name (if applicable)

Check Desired Action
☐ Add ☐ Cancel ☐ Change

Group Administrator's Signature (required) _____ Date _____
Employee ID Number _____ Department Number _____

Medical Information

00036755 — Medical Group Number (8 digits)
Subgroup _____ Class _____

CHANGE EFFECTIVE DATE: _____

Subscriber Status:
☐Actively Working
☐Retired
☐Disabled
☐Cancelled
☐COBRA

Reason for Enrollment/Change

☐ New Hire/Rehire/Newly Eligible
☐ Open Enrollment
☐ Loss of Other Coverage
☐ Marriage/Formation of Domestic Partnership
☐ Birth/Adoption/Custody
☐ Retirement **EVENT DATE:** _____

Medical Plan Selection - Active Employees

Coverage Level

☐ (DAA) Signature Platinum $15/$25 Copay — ☐Individual / ☐ Family

Medical Plan Selection - Retirees

Coverage Level

☐ (DAA) Signature Platinum $15/$25 Copay — ☐ Self ☐ Spouse/DP/Child ☐ Family

☐ (JA) Classic Blue Supplement — ☐ Self ☐ Spouse

Note: Retirees and dependents not yet Medicare eligible shall be enrolled in the Platinum plan. Retirees and dependents who are Medicare eligible shall be enrolled in the Classic Blue Secure Medicare Supplement plan. Retirees covering only one dependent (spouse/domestic partner or child) on the Platinum and/or Classic Blue Secure Plan(s) will be billed for two individual plans (i.e. two Platinum Individual plans, a Platinum Individual and Classic Blue Secure Individual plan, or two Classic Blue Secure Individual plans). Retirees covering two or more dependents will pay the cost of the Platinum family plan.

Reason for Cancellation/Dependent Removal

☐ Termination/Retirement/Loss of Eligibility
☐ Open Enrollment
☐ Gain of Other Coverage
☐ Divorce/Legal Separation
☐ Death

EVENT DATE: _____

Section 2: Subscriber's Information

_____ **Last Name** _____ **First Name** (MI) **DOB:** ____/____/_____ **SSN:** _____

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: _____

Medicare ID#: _____ Part A Effective: ____/____/_____ Part B Effective: ____/____/_____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Email Address _____ **Phone Number** _____

Dependent Eligibility Verification Requirements:
If you are enrolling a Spouse or Domestic Partner in coverage, you must attach a copy of your Marriage Certificate or Certificate of Domestic Partnership/Affidavit of Domestic Partnership.
If you are enrolling any Dependent Children (including Step Children, Children of a Domestic Partner, or any child over whom you have custody, you must attach to your application copies of birth certificate(s) and copies of adoption paperwork or court order of custody (if applicable).

Section 3: Dependent Information - Who do you want to enroll in coverage?

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

________________________ ________________________ **DOB:** _____ **/**_____ **/**_________ **SSN:** ________________________

Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ____

Medicare ID#: ____________________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

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Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ____

Medicare ID#: ____________________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

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Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ____

Medicare ID#: ____________________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

Section 4: Coordination of Benefits - Other Health Insurance Coverage

Will anyone you're planning to cover also be covered under another health insurance plan? Please list details below.

Person(s) covered by other health insurance: ☐ Self ☐ Spouse/Domestic Partner ☐ Child(ren)

Name of Policy Holder: ________________________________ Insurance Plan:________________________________

Subscriber ID#: ____________________________ Effective Date: ____ /____ /_________

Section 5: Cancellation Information - Who do you want to remove from coverage?

Whose coverage would you like to cancel?

☐ Self ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ Family (All)

Specify child(ren) to remove (if not all): ____

Section 6: 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 acknowledgement 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. 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 out-of-network benefit that 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. 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:** _____ **/**_____ **/**_________

Section 3 (continued): Additional Dependents

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

__________________ __________________ **DOB:** _____ /_____ /_________ **SSN:** __________________

Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ______________________________

Medicare ID#: ____________________ Part A Effective: _ ______ Part B Effective: ______

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

__________________ __________________ **DOB:** _____ /_____ /_________ **SSN:** __________________

Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ______________________________

Medicare ID#: ____________________ Part A Effective: ______ ______ ______ Part B Effectiv ______ ______ ______

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Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ______________________________

Medicare ID#: ____________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

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Last Name **First Name** (MI)

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Medicare ID#: ____________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

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Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ______________________________

Medicare ID#: ____________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

☐**Spouse** ☐**Domestic Partner** ☐**Dependent Child** ☐**Disabled Dependent Child** (Separate application form required)

__________________ __________________ **DOB:** _____ /_____ /_________ **SSN:** __________________

Last Name **First Name** (MI)

Gender: ☐Male ☐Female ☐Non-binary ☐Prefer to Self-Identify: ______________________________

Medicare ID#: ____________________ Part A Effective: ______ /______ /_________ Part B Effective: ______ /______ /_________

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information (to be completed with your Group Administrator)

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical group numbers and information must be populated. Select who you need coverage for on the medical plan. Next, select the medical plan you are enrolling in. All products may not be applicable to all enrollees. Please check with your Group Administrator. Indicate the subscriber's status. 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 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.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this optional gender identity section of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Dependent Information - Who do you want to enroll in coverage?

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 ACA.* 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 4: Coordination of Benefits - Other Health Insurance Coverage

Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 5: Cancellation Information - Who do you want to remove from coverage?

If you are cancelling coverage, complete the appropriate section of the form. List each dependent to be cancelled and make sure to include the date the coverage is to be cancelled.

Section 6: Release - You must sign and date this form to be eligible for health insurance.

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.