



GROUP ENROLLMENT FORM

PO Box 22999, Rochester, New York 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy Check if name change Check if new address

✓ CHECK DESIRED ACTION		✓ CHECK DESIRED COVERAGE - Select One Product Option			✓ CHECK PERSON(S) COVERED			
<input type="checkbox"/> Add Subscriber (AA)	<input type="checkbox"/> BluePPO (BP)	<input type="checkbox"/> HMOBlue (MO)	<input type="checkbox"/> BCBS Comprehensive (CO)	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)	
Date of Hire/Event ___/___/___	<input type="checkbox"/> BluePPO/HSA (HF)	<input type="checkbox"/> HMOBlue 25 (MZ)	<input type="checkbox"/> Bassett Plus PPO (AS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coverage Eff Date ___/___/___	<input type="checkbox"/> BluePPO Savings Account Plan (DC)	<input type="checkbox"/> HMOBlue Essential (BL)	<input type="checkbox"/> Bassett Plus HMO (AT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Add Dependent (AB)	<input type="checkbox"/> BluePreferred PPO (PN)	<input type="checkbox"/> HMOBlue Value (HB)	<input type="checkbox"/> HMOBlue NYSCOP (MC)	MEDICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Event ___/___/___	<input type="checkbox"/> BlueEPO (BE)	<input type="checkbox"/> Secure Comp (SC)	<input type="checkbox"/> HMOBlue Preferred NYSCOP (MY)	DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coverage Eff Date ___/___/___	<input type="checkbox"/> BlueEPO Balance (UE)	<input type="checkbox"/> Senior Ins. High Option (SH)	<input type="checkbox"/> Traditional RX only (RX)					
	<input type="checkbox"/> FourFront (EF)	<input type="checkbox"/> BluePoint (BT)						
	Blue Healthy Choices:	<input type="checkbox"/> BluePoint 2 (SF)						
	<input type="checkbox"/> Fit & Healthy (FH)	<input type="checkbox"/> BCBS Traditional (TR)						
	<input type="checkbox"/> Healthy Family (FM)							

<input type="checkbox"/> Change Coverage (AC)	✓ CHECK DESIRED COVERAGE		
Coverage Eff Date ___/___/___	<input type="checkbox"/> Dental (DE)	<input type="checkbox"/> Dental Blue Classic (DI)	<input type="checkbox"/> Dental Blue Options (DJ)

<input type="checkbox"/> Transfer to COBRA (AD)	SUBSCRIBER INFORMATION - Must be completed			✓ Check if Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage: ___/___/___
<input type="checkbox"/> (S)ubscriber <input type="checkbox"/> (D)isabled	Social Security # _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate: ___/___/___		
<input type="checkbox"/> (M) Dependent	Last Name _____	First _____			
Date of Event ___/___/___	Street _____				
	City _____	State _____	Zip _____		
<input type="checkbox"/> Cancel Subscriber (S)	Day Phone: _____	E-mail Address: _____			
<input type="checkbox"/> Cancel Dependent (M)	Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate reason: <input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD			
<input type="checkbox"/> (M)edical	Medicare Claim #: _____	Medicare Part A Eff Date: _____	Medicare Part B Eff Date: _____		
<input type="checkbox"/> (D)ental	Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired, Provide Retirement date ___/___/___				
Reason Code _____ (See back)					
Cancellation Date ___/___/___	HMO, Bassett and BluePoint must select a Primary Care Physician (PCP)				
If Reason Code SD or DM, indicate	Primary Care Physician (Last) _____ (First) _____	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N			
Date of Death ___/___/___	OB/GYN Physician (Last) _____ (First) _____	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

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

<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> (H) Disabled Dependent <input type="checkbox"/> Other _____	Primary Care Physician	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Student(T) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time # of Credit Hours: _____	Last _____	First _____
Graduation Date: _____	OB/GYN Provider	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
School Name: _____	Last _____	First _____
Social Security # _____	Enrolled with Medicare? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, indicate reason: <input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: ___/___/___	Medicare Claim #: _____	
Last Name (if different): _____ First Name: _____	Medicare Part A Eff Date: _____	Medicare Part B Eff Date: _____
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> (H) Disabled Dependent <input type="checkbox"/> Other _____	Primary Care Physician	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Student(T) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Graduation Date: _____	Last _____	First _____
School Name: _____	OB/GYN Provider	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Social Security # _____	Last _____	First _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: ___/___/___	Enrolled with Medicare? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, indicate reason: <input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
Last Name (if different): _____ First Name: _____	Medicare Claim #: _____	
	Medicare Part A Eff Date: _____	Medicare Part B Eff Date: _____
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> (H) Disabled Dependent <input type="checkbox"/> Other _____	Primary Care Physician	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Student(T) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Graduation Date: _____	Last _____	First _____
School Name: _____	OB/GYN Provider	Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Social Security # _____	Last _____	First _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: ___/___/___	Enrolled with Medicare? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, indicate reason: <input type="checkbox"/> Age <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
Last Name (if different): _____ First Name: _____	Medicare Claim #: _____	
	Medicare Part A Eff Date: _____	Medicare Part B Eff Date: _____

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 all that apply: Medical Dental Vision Prescription Drug

Are you keeping this coverage? Yes No -- If No, indicate cancel date ___/___/___

Policyholder's Name _____ Effective Date: ___/___/___ Did this insurance cover Insured Insured and Family

✓ Check previous insurance company from list below and indicate ID #: _____

(B) Excensus BlueCross BlueShield

(O) Other - BlueCross BlueShield Plan. 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 Representative) Shaded areas are 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 #	Employer Name:
Medical				Employee Status <input type="checkbox"/> (A) Active: <input type="checkbox"/> (A) Full Time <input type="checkbox"/> (A) Part-time - # of Hours _____ <input type="checkbox"/> (A) Cobra <input type="checkbox"/> (A) Termination <input type="checkbox"/> (R) Retired
Dental				Payroll Location # _____ Employee # _____
				Group Rep Signature _____ Date _____
				Return Original to PO Box 22999, Rochester, NY 14692

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 Representative 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 Cancel Subscriber (S) Box
- Check Products to be cancelled (Medical, Dental)
- 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(11)	*CE – Cobra End Date (29)
SD – Subscriber Deceased (05)	CP – Commercial (09)
SR – Subscriber Request (02)	SB – Spouse's Excellus BCBS
CB – Cobra Begin Date	MC – Medicaid
CD – Cobra Disabled Date	MX – Medicare (03)

To Cancel a Dependent using the Group Enrollment Form:

- Check Cancel Dependent (M) box
- Check Products to be cancelled (Medical, Dental)
- 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 (25)	CB – COBRA Begin Date
OA – Dependent Over Age (20)	MR – Subscriber Request (02)
DM – Deceased (05)	DV – Divorce (25)
MS – Ineligible Student (28)	MX – Medicare (03)

If the only change is one of the following, please call Customer Service at the telephone number listed below. A Group Enrollment Form is not required.

- Address
- Birthdate
- PCP or OB/GYN

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

SUBSCRIBER If you or your dependents are Medicare eligible, complete the Medicare Eligible – Group Enrollment Form. If you are disabled, see your Group Representative to determine eligibility for OBRA. If eligible, complete the appropriate form.

FAMILY MEMBER QUALIFIED GUIDELINES:

If there are more than three members please use an additional form.

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent and student age for your employer group
 - Unmarried child, natural, adopted or stepchild
 - A full-time student (indicate under Relationship)
 - Chiefly dependent upon you for support
- **Other: The following dependents have additional eligibility requirements.**
 Dependents pending adoption, grandchild dependent*, 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 disabled dependent who is over the dependent age for your employer group. **Please contact Customer Service for the appropriate form.**
 *if supporting documentation is attached.

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.
 The certificate or contract for which application is being made may impose a waiting period of 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.

EMPLOYER INFORMATION

This section to be completed by the Employer Group Representative.
 Complete only the coverage section (Medical, Dental) that is applicable to the employee's request.

If you have any questions, please contact Customer Service

Traditional or Comprehensive: 1-800-765-5226

HMO or Point of Service: 1-800-722-7884

PPO: 1-877-381-8659

Membership Inquiries:

1-800-765-5224