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

HealthyBlue
GROUP ENROLLMENT FORM

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 ___/___/___

❑ **Transfer** to COBRA (AD)
❑ (S)ubscriber
❑ (M) Dependent
❑ (D)isabled
Date of Event ___/___/___

❑ **Cancel** Subscriber (S)
❑ **Cancel** Dependent (M)
❑ (M)edical
❑ (D)ental
Reason Code (see back)________
Cancellation Date ___/___/___

Select the medical or dental plan offered by your employer

Copay Option
choose 1 copay
❑$10 PCP / $20 Specialist (A4)
❑$15 PCP / $25 Specialist (A1)
❑$25 PCP / $40 Specialist (A2)
❑$30 PCP / $50 Specialist (A3)
❑$40 PCP / $60 Specialist (A5)

HDHP Option
choose 1 deductible
$1,300 S / $2,600 F
❑ 20% coinsurance (C1)
❑ 0% coinsurance (C4)
❑$1,800 S / $3,600 F (C5)
❑$2,600 S / $5,200 F (C2)
❑$5,500 S / $11,000 F (C3)

Copay & Deductible Option
choose 1 deductible and 1 copay

❑ $250 S / $750 F
❑$10 PCP / $20 Specialist (D1)
❑$15 PCP / $25 Specialist (D3)
❑$25 PCP / $40 Specialist (D5)
❑$30 PCP / $50 Specialist (D7)
❑$40 PCP / $60 Specialist (D9)

❑ $500 S / $1,500 F
❑$10 PCP / $20 Specialist (B7)
❑$15 PCP / $25 Specialist (B1)
❑$25 PCP / $40 Specialist (B3)
❑$30 PCP / $50 Specialist (B5)
❑$40 PCP / $60 Specialist (B9)

❑ $1,000 S / $3,000 F
❑$10 PCP / $20 Specialist (B8)
❑$15 PCP / $25 Specialist (B2)
❑$25 PCP / $40 Specialist (B4)
❑$30 PCP / $50 Specialist (B6)
❑$40 PCP / $60 Specialist (E1)

❑ $2,000 S / $6,000 F
❑$10 PCP / $20 Specialist (D2)
❑$15 PCP / $25 Specialist (D4)
❑$25 PCP / $40 Specialist (D6)
❑$30 PCP / $50 Specialist (D8)
❑$40 PCP / $60 Specialist (E2)

❑ Dental Blue Classic (DI) ❑ Dental Blue Options (DJ)

✓ CHECK PERSON(S) COVERED

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

SUBSCRIBER INFORMATION - Must be completed

Social Security # ☐☐☐-☐☐-☐☐☐☐ Sex: ❑ M ❑ F Date of Birth ___/___/___
Last Name______________________ First______________________
Street____
City______________________ State__________ Zip__________
Day Phone: ☐☐☐-☐☐☐-☐☐☐☐ Email Address:______________________
Enrolled with Medicare? ❑Yes ❑ No If yes, indicate reason: ❑ Age ❑ Disabled ❑ ESRD (first date of dialysis ___/___/___)
Medicare Claim #: ______________________ Medicare Part A Eff Date: ___/___/___ Medicare Part B Eff Date: ___/___/___
Employment status: ❑ Active ❑ Retired, Provide Retirement date ___/___/___

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

	Social Security #	Sex	Date of Birth (mm/dd/yy)
❑ (S)pouse ❑ Domestic (P)artner *Last Name:* *First Name:*		❑M ❑F	___/___/___
❑ (D)ependent ❑ (H)Disabled ❑ (F)oster/Adopted ❑ Student ❑Other________ *Last Name:* *First Name:*		❑M ❑F	___/___/___
❑ (D)ependent ❑ (H)Disabled ❑ (F)oster/Adopted ❑ Student ❑Other________ *Last Name:* *First Name:*		❑M ❑F	___/___/___
❑ (D)ependent ❑ (H)Disabled ❑ (F)oster/Adopted ❑ Student ❑Other________ *Last Name:* *First Name:*		❑M ❑F	___/___/___

OTHER COVERAGE INFORMATION

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

1. Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Medicare or Medicaid)?
❑ Yes ❑ No ✓ Check: ❑ Medical and/or ❑ Dental Are you keeping this coverage? ❑ Yes ❑ No ✓ Check: ❑ Medical and/or ❑ Dental
Other plan covers: ❑ Self ❑ Spouse ❑ Child(ren) ❑ Entire family
Indicate Other Plan Name:______________________ Policy ID number______________________
Effective date:____/____/____ Termination date: ____/____/____
2. While enrolled in Excellus BCBS will any member of your family be covered by Medicare: ❑ Yes ❑ No If yes, answer the following
Name of person with Medicare:______________ ❑ Spouse ❑ Dependent If yes, indicate reason: ❑ Disability ❑ Retired ❑ ESRD (first date of dialysis ___/___/___)
MEDICARE CLAIM #______________________ Part A effective date: ___/___/___ Part B effective date: ___/___/___

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/Representative)

* 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 #	Check digit	Pkg #	Employer Name:
Medical				Employee Status ❑ (A)Active ❑ (A)COBRA ❑ (A)Cancellation ❑ (R)etired
Dental				Department #* Employee #*

Group Rep Signature/Date:

A Group Enrollment Form is not required for a change of address or correction to a date of birth. Please contact Customer Service at the number listed on your member ID card.

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/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 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 Eligible (11)
CP -- Commercial (09)
CB – Cobra Begin Date
CD – Cobra Disabled Date
TT – Transfer to Traditional
TH – Transfer to HMO (73)
TP – Transfer to POS (73)
CE – Cobra End Date (29)
SR – Subscriber Request (02)
SD – Subscriber Deceased (05)
SB – Spouse's Excellus BCBS
MC – Medicaid
MX – Medicare (03)

To Cancel a Dependent using the Group Enrollment Form:

- check 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)
OA – Dependent Over Age (20)
DM – Deceased (05)
MS – Ineligible Student (28)
MB – COBRA Begin Date
MR – Subscriber Request (02)
DV – Divorce (25)
CB – Cobra Begin Date
MX- Medicare (03)

DESIRED COVERAGE 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 five members please use an additional form.

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
  - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements. **Dependents pending adoption, foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a handicapped 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.
- 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 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