



HealthyBlue GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 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

PLEASE PRINT CLEARLY

Form section for selecting medical or dental plan and checking desired actions. Includes options for Copay, Deductible, and HDHP, and checkboxes for adding subscribers or dependents.

SUBSCRIBER INFORMATION - Must be completed. Includes fields for Social Security #, Last Name, First Name, Street, City, State, Zip, Date of Birth, Sex, and Medicare information.

FAMILY MEMBER INFORMATION. Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled. Includes fields for Last Name, First Name, Social Security #, Sex, and Date of Birth for multiple family members.

OTHER COVERAGE INFORMATION. In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer. Includes questions about other insurance and Medicare coverage.

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...

Subscriber Signature and Date fields. EMPLOYER INFORMATION (Must be completed by Group Administrator/Representative). Includes questions about waiting periods and a table for Coverage, Group/Sub Group #, Check digit, Pkg #, Employer Name, Employee Status, Department #, and Employee #.

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

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) | MB – COBRA Begin Date |
| OA – Dependent Over Age (20) | MR – Subscriber Request (02) |
| DM – Deceased (05) | DV – Divorce (25) |
| MS – Ineligible Student (28) | 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