



GROUP ENROLLMENT FORM

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PO Box 22999, Rochester, New York 14692
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Instructions on Back. All Dates = mm/dd/yy Check if name change Check if new address Please print clearly using Blue Ink.

Form section for checking desired actions and coverage options, including checkboxes for adding subscribers, dependents, or changing coverage, and a table for selecting desired coverage options like dental, vision, and drug.

Form section for subscriber information, including fields for name, address, date of birth, marital status, and Medicare information, along with a section for selecting a primary care physician.

Form section for family member information, featuring a table with columns for relationship, name, birthdate, and insurance status for multiple family members.

Form section for other coverage information, including a declaration of whether the applicant has other insurance and a list of previous insurance companies.

Form section for a release statement, where the applicant agrees to provide accurate information and understands the terms of the insurance policy.

Form section for employer information, including a question about waiting periods and fields for employer name and contact details.

Form section for coverage details, including a table for medical, dental, and vision coverage, and a signature line for the group representative.

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, Vision, Drug)
- 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)	TH – Transfer to HMO (73)
SR – Subscriber Request (02)	CP – Commercial (09)
CB – Cobra Begin Date	SB – Spouse's Excellus BCBS
CD – Cobra Disabled Date	MC – Medicaid
TT – Transfer to Traditional	TP – Transfer to POS (73)
	MX – Medicare (03)

To Cancel a Dependent using the Group Enrollment Form:

- Check Cancel Dependent (M) box
- Check Products to be cancelled (Medical, Dental, Vision, Drug)
- 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 indicated on your identification card. 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 questions regarding Medicare Coverage.

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 and signed by the Employer Group Representative.
 Complete only the coverage section (Medical, Dental, Vision, Drug) that is applicable to the employee's request.