



GROUP ENROLLMENT FORM

Excellus Use Only - Do Not Write in this space

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 Please print clearly using Blue Ink.

Check Desired Action, Check Desired Coverage - Select One Product Option, Check Person(s) Covered. Includes checkboxes for Add Subscriber, Add Dependent, Change Coverage, Transfer to COBRA, Cancel Subscriber, etc.

Check Desired Coverage. Includes checkboxes for Dental, Dental Blue PPO, Vision, Drug, etc.

Subscriber Information - Must be completed. Includes fields for Social Security #, Sex, Birthdate, Name, Street, City, State, Zip.

Medical Information. Includes checkboxes for Medicare, Employment status, and Medicare Part A/B Eff Dates.

Physician Information. Includes fields for Primary Care Physician and OB/GYN Physician (Last, First) and Current patient status.

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

Family Member Information Form 1. Includes fields for relationship, graduation date, school name, social security, sex, birthdate, and name.

Family Member Information Form 2. Includes fields for relationship, graduation date, school name, social security, sex, birthdate, and name.

Family Member Information Form 3. Includes fields for relationship, graduation date, school name, social security, sex, birthdate, and name.

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.

Other Coverage Information. Includes checkboxes for Yes/No, current coverage status, and previous insurance company selection.

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.

Employer Information. Includes checkboxes for waiting period and start/end dates.

Table with 5 columns: Coverage, Group/Sub Group #, Chk Digit, Pkg #, Employer Name. Rows include Medical, Dental, Drug, and Vision.

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.