Excellus | National strength. Local focus. Individual care.

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply to you

- Additional instructions are included
- This application cannot be processed without this information and a signature

FOR INTERNAL USE ONLY
EC _____

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

_____ Medical Group Number (8 digits)

_____ Medical Subgroup Number (4 digits)

_____ Medical Class Number (4 digits)

_____ Dental Group Number

_____ Dental Subgroup Number

_____ Department Number

_____ Employee Number

_____ Employer Name

_____ Association/Chamber Name (if applicable)

_____ Group Administrator's Signature

_____ Date

Subscriber Status:

☐New Hire - Date of Hire: ___ /___ /____

☐Rehire - Date of Rehire: ___ /___ /____

☐COBRA - Effective Date: ___ /___ /____

☐Retired - Effective Date: ___ /___ /____

☐Canceled - Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse

☐Dependent Reached Max Age ☐ Other: _____

Section 2: Your Information

This section should be completed by the Subscriber

_____ Last Name _____ First Name _____ MI _____ Social Security #**

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

_____ Street Address _____ City _____ State _____ Zip

_____ Phone _____ Email

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Medicare Number (if applicable) Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced Marital Status Event Date ___/___/_____

Section 3: Subscriber Medical Plan Selection

__ Sig Copay 1 Opt 1 (DAA)
__ Sig Copay 1 Opt 2 (DAI)
__ Sig Copay 1 Opt 3 (DAJ)
__ Sig Copay 1 Opt 4 (DAK)
__ Sig Copay 1 Opt 5 (DAL)

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child(ren)

☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/_____

Section 4: Subscriber Dental Plan Selection

Please select plan if applicable:

- ❑ Smile Saver I (EAA)
- ❑ Smile Saver I Modified (EAB)
- ❑ Smile Saver II (EAC)
- ❑ Smile Saver III (EAD)
- ❑ Smile Saver IV (EAE)
- ❑ Smile Saver IV Modified (EAF)
- ❑ Smile Saver IV Modified with Orthodontics (EAG)
- ❑ Smile Saver V (EAH)
- ❑ Smile Saver VI (EAI)
- ❑ Smile Saver VII (EAJ)
- ❑ Smile Saver VIII (EAK)

Dental Blue Options

- ❑ DBO Orthodontics not covered (EBA)
- ❑ DBO Orthodontics not covered (2nd option) (EBG)
- ❑ DBO Cosmetic Orthodontics to age 19 (EBB)
- ❑ DBO Orthodontics to age 19 (EBC)
- ❑ DBO Orthodontics to age 19 (2nd option) (EBE)
- ❑ DBO Orthodontics all eligible(EBD)

Dental Blue Classic

- ❑ DBC Orthodontics not covered (ECA)
- ❑ DBC Orthodontics to age 19 (ECB)

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only ☐Self & Child(ren)
☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/_____

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage
☐COBRA
☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance
☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage
☐Address Change ☐Last Name Change ☐A move in or out of service area
☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other _____

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber ☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____
☐Dependent(s) (List each dependent)
☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____

Spouse/DP_____ **Dependent 2**_____ **Dependent 3** _____ **Dependent 4** _____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage
☐Coverage through spouse/domestic partner ☐Loss of eligibility through employer or discontinuation of employer coverage
☐Other _____

Section 7: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child *Separate form required
☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: M ☐ F ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #**

Is dependent a full time student over age 19? ☐Yes ☐No If yes, please provide name of college/university _____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No

If yes, are you keeping the coverage? ☐Yes ☐No What is the name of the other carrier? _____

If no, when will the coverage cancel? __/__/__

Policyholder's name _____ ID# _____

Effective Date: ___/___/____

Who did the insurance cover? ☐Self Only ☐Self & Child (ren)
☐Self & Spouse/Domestic Partner ☐Family

Section 9: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

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 out-of-network benefit that 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.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

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.

Subscriber Signature_____

Date_____

Please return to PO Box 21146, Eagan, MN 55121
If you have questions, please contact your Group Administrator.
Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1
This section should be completed by a Group Benefits Administrator.

Section 2
This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 3
Column A – This column is populated with the plan name your group has selected.
Column B – Select who you want to cover on this medical plan.

Section 4
Column A – Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.
Column B – Select who you want to cover on this dental plan.

Section 5
Select the box that describes what you need to do regarding health insurance coverage and include the date of the event. An event is 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 for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you must also check coverage type and persons to be covered, and Dependent Information section.

You may be required to provide documentation of certain events.

Section 6
If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 7
Please include information about all the people who you would like coverage for.
Use an additional application if more than five people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 8
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Child Health Plusמעמבער אדער Managed Medicaid, ביטע רופט 1-800-650-4359. מעמבער, ביטע רופט 1-877-626-9298. אלע אנדערע ביטע רופט Essential Plan אויב איר זענט אן 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Child Health Plus أو Managed Medicaid ، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan ، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid اگر آپ 1-800-650-4359 پر کال کریں۔ ممبر ہیں تو براہ کرم Essential Plan1- کے ممبر ہیں تو براہ کریم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.