Excellus National strength. Local focus. Individual care.

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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 Hybrid 1 Opt 1 (DAB)
_ Sig Hybrid 1 Opt 3 (DAN)
_ Sig Hybrid 2 Opt 2 (DAQ)
_ Sig Hybrid 3 Opt 1 (DAD)
_ Sig Hybrid 3 Opt 3 (DAV)
_ Sig Hybrid 1 Opt 2 (DAM)
_ Sig Hybrid 2 Opt 1 (DAC)
_ Sig Hybrid 2 Opt 3 (DAR)
_ Sig Hybrid 3 Opt 2 (DAU)

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

Smile Saver
- ❑ 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 22999, Rochester, NY 14692
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.