

ENROLLMENT INQUIRY TRAINING GUIDE



Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association



CONTENTS

<u>Overview of Forms</u>	2
<u>Review of Forms</u>	4
<u>Dashboard Review</u>	9
<u>Creating a New Case</u>	14
<u>Market Segment: Commercial Group</u>	18
<u>Market Segment: Medicare Employer/Union Group</u>	40
<u>Submitting a Case</u>	54

Overview of Forms

Process	Documentation Needed
New Add	Enrollment Application
Adding Dependent	Enrollment Application
QMCSO	Court order, QMCSO Certification Form , completed application if dependent is not already enrolled.
QMCSO Disenrollment	QMCSO Disenrollment Form , and court order
Custodial Parent	Court order, completed Enrollment Application if dependent is not already enrolled.
Disabled Dependent	Adult Disabled Dependent Form Application , if dependent is not already enrolled or becomes disabled prior to maximum age of contract.
Key Employee	Enrollment Application , letter on company letterhead. Letter must contain required information, refer to your Group Administrator's Guide under Enrollment and Maintenance procedures.

Process	Documentation Needed
Student Certification	Enrollment Application , Student Certification Form
Demographic Change	Enrollment Application or enter action needed in the Additional Details section of request
Cancel	<ul style="list-style-type: none"> • Enrollment Application or Membership Cancel Worksheet
Reinstate	<ul style="list-style-type: none"> • If within 30 days from cancellation date, okay to reinstate without a new application. Enter action needed in the Additional Details section of request • If over 30 days from the cancellation date, a new Enrollment Application is needed
Medicare	Medicare form or Enrollment Application
COBRA	Enrollment Application and COBRA Form is to be provided by either the employer group or Lifetime Benefit Solution (LBS) based on who is managing the COBRA benefit.

New Add Required Fields Enrollment Forms Overview

POS/HMO – Requires Primary Care Physician (PCP)

Excelsus
A North Carolina member of the Blue Cross Blue Shield Association

Commercial Group Health Insurance Application/Change Form **CONFIDENTIAL**

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name: _____ Association/Chamber Name (if applicable): _____

Group Administrator's Signature (required): _____ Date: _____ Employment Number: _____ Department Number: _____

Medical Information Who's covered? Self Only Self & Child(ren) Self & Spouse/Domestic Partner Family

Medical Group Number (8 digits): _____

Subgroup Class: _____ Medical Effective Date: _____

Medical Plan Selection

Please choose plan options from dropdowns

Subscriber's Information

Last Name: _____ Birthdate: _____

First Name: _____ Gender: Female Male Gender X

Middle Initial: _____ Title (e.g., Jr, Sr, III, etc.): _____ Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____

Street Address: _____ Social Security Number**: _____

City: _____ State: _____ Date of Hire/Rehire: _____

Zip Code: _____ Phone: _____ Retirement Date: _____

Subscriber's Medicare Number (if applicable): _____

Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____

Primary Care Physician's Last Name: _____ First Name: _____ Zip Code: _____

Ob/Gyn's Last Name: _____ First Name: _____ Zip Code: _____

APP-352 (0723) E Mid/Large Group Page 1

Only fill out the product you are enrolling into (Medical, Dental, Vision)

Only required if you are adding dependents

This is needed only if you are a female over the age of 19

Subscriber's Last Name: _____

Section 3: Reason for enrollment or change To be completed by the Group Administrator Not required for cancellations

Enrollment Opportunity: New Hire Rehire Open Enrollment Medicare eligible

Special Enrollment Opportunity: Newly Eligible Dependent: Newborn Marriage Other _____

Change in employment status A move in or out of the service area Involuntary loss of coverage Former dependent regains eligibility

COBRA Election - Please indicate the reason for COBRA if applicable:

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

Disability Dependent Reached Max Age Other: _____

Demographic Change: Address Birthdate Subscriber Name Dependent Name Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
Cancel Codes: SB02-Left Employment SB06-Employee No Longer Wants Coverage* (subscriber request) SB07-Deceased	SB58-Change in Employee Eligibility Status SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)	SB08-Subgroup Transfer* SB57-Layoff Without Benefits		

Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
* = Not eligible for COBRA					

Cancel Codes:
M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

Spouse Domestic Partner Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

Last Name (if different): _____ Title: _____ First Name: _____ MI: _____ Social Security Number **: _____

Gender: Female Male Gender X Birthdate: _____

Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____

Is dependent a full-time student over age 19? Yes No Married? No Yes _____ Expected Graduation Date: _____

If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No

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): _____

Primary Care Physician's Last Name: _____ First Name: _____ Zip Code: _____ Ob/Gyn's Last Name: _____ First Name: _____ Zip Code: _____

Additional Dependent(s)

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

Last Name (if different): _____ Title: _____ First Name: _____ MI: _____ Social Security Number **: _____

Gender: Female Male Gender X Birthdate: _____

Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____

Is dependent a full-time student over age 19? Yes No Married? No Yes _____ Expected Graduation Date: _____

If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No

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): _____

Primary Care Physician's Last Name: _____ First Name: _____ Zip Code: _____ Ob/Gyn's Last Name: _____ First Name: _____ Zip Code: _____

APP-352 (0723) E Mid/Large Group Page 2

Subscriber's Last Name: _____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

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

Gender: Female Male Gender X
 Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____

Birthdate _____

Is dependent a full-time student over age 19? Yes No Married? No Yes Expected Graduation Date: _____
 If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No

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) _____

Primary Care Physician's Last Name _____ First Name _____ Zip Code _____
 Ob/Gyn's Last Name _____ First Name _____ Zip Code _____

Note: Use an additional application or addendum if more than three dependents need coverage

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? Yes No
 If yes, what type of coverage? Medical Dental
 What is the effective date of the other coverage? Medical: _____ Dental: _____
 What is the name of the other carrier? _____
 Are you keeping the coverage? Yes No
 If no, when will the coverage end? Medical: _____ Dental: _____
 Policyholder's name _____ ID#(s) _____
 Who did the insurance cover? Self Only Self & Spouse/Domestic Partner Self & Child(ren) Family

Section 7: 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.
 Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.
HEALTH MAINTENANCE ORGANIZATION (HMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. **POINT OF SERVICE (POS)** I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

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 P.O. Box 21146 Eagan, MN 55121-0146
 If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Only complete if other coverage is applicable.

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information
 This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

Section 2: Subscriber's Information
 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. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Reason for enrollment or change
 Select the box(es) that describe(s) the reason for this enrollment or change 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. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?
 If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)
 Please include information about all the people who you would like coverage for.
 Use an additional application or addendum if more than three dependents 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 county clerk)
- 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 disabled dependent who is over the maximum 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.
 * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.
 A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

Section 6: Other coverage information (Required)
 Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
 Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

PPO/EPO/Indemnity – No Primary Care Physician (PCP)

Excelsus
A member independent licensee of the Blue Cross Blue Shield Association

Commercial Group Health Insurance Application/Change Form
Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

FOR INTERNAL USE ONLY
HIOS ID# _____
EC _____

CONFIDENTIAL

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name: _____ Association/Chamber Name (if applicable): _____
 Group Administrator's Signature (required): _____ Date: _____ Employee Number: _____ Department Number: _____

Medical Information Who's covered?
 Self Only
 Self & Child(ren)
 Self & Spouse/Domestic Partner
 Family
 Medical Group Number (8 digits): _____
 Subgroup: _____ Class: _____ Medical Effective Date: _____

Subscriber Status:
 Working
 Retired
 Disabled
 Canceled
 COBRA

Dental Information Who's covered?
 Self Only
 Self & Child(ren)
 Self & Spouse/Domestic Partner
 Family
 Dental Group Number: _____
 Subgroup: _____ Class: _____ Dental Effective Date: _____

Vision Information Who's covered?
 Self Only
 Self & Child(ren)
 Self & Spouse/Domestic Partner
 Family
 Vision Group Number: _____
 Subgroup: _____ Class: _____ Vision Effective Date: _____

Medical Plan Selection
 Please choose plan options from dropdowns

Dental Plan Selection
 Please choose plan options from dropdowns

Vision Plan Selection
 Please choose plan options from dropdowns

Section 2: Subscriber's Information

Last Name: _____ Birthdate: _____
 First Name: _____ Gender: Female Male Gender X
 Middle Initial: _____ Title (e.g., Jr, Sr, III, etc.): _____ Gender Identity (optional): Prefer not to say Transgender Male Transgender Female Non-binary
 Social Security Number**: _____ Date of Hire/Rehire: _____
 Street Address: _____ Retirement Date: _____
 City: _____ State: _____ Subscriber's Medicare Number (if applicable): _____
 Zip Code: _____ Phone: _____

APP-352 (0723) E Mid/Large Group Page 1

Only fill out the product you are enrolling into (Medical, Dental, Vision)

Only required if you are adding dependents

Subscriber's Last Name: _____

Section 3: Reason for enrollment or change To be completed by the Group Administrator. Not required for cancellations.

Enrollment Opportunity: New Hire Rehire Open Enrollment Medicare eligible
Special Enrollment Opportunity: Newly Eligible Dependent: Newborn Marriage Other
 Change in employment status A move in or out of the service area Involuntary loss of coverage Former dependent regains eligibility
 Date of Event: _____

COBRA Election - Please indicate the reason for COBRA if applicable:
 Left Employment/Retired Divorce/Legal Separation Loss of Student Status Death of Spouse
 Disability Dependent Reached Max Age Other: _____

Demographic Change: Address Birthdate Subscriber Name Dependent Name Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Cancel Codes:
 SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
 SB06-Employee No Longer Wants Coverage* (subscriber request) SB57-Layoff Without Benefits
 SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Cancel Codes:
 M002-Deceased* M005-Divorced M010-Coverage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
 M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
 M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

Spouse Domestic Partner Dependent Child Adult Disabled Dependent (Separate application form required)
 Other

Last Name (if different): _____ Title: _____ First Name: _____ MI: _____ Social Security Number **: _____
 Gender: Female Male Gender X Birthdate: _____
 Gender Identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____
 Is dependent a full-time student over age 19? Yes No Married? No Yes Expected Graduation Date: _____
 If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No
 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): _____

Additional Dependent(s)

Dependent Child Adult Disabled Dependent (Separate application form required) Other

Last Name (if different): _____ Title: _____ First Name: _____ MI: _____ Social Security Number **: _____
 Gender: Female Male Gender X Birthdate: _____
 Gender Identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____
 Is dependent a full-time student over age 19? Yes No Married? No Yes Expected Graduation Date: _____
 If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No
 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): _____

APP-352 (0723) E Mid/Large Group Page 2

Subscriber's Last Name: _____

Dependent Child Adult Disabled Dependent (Separate application form required) Other _____

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

Gender: Female Male Gender X
 Gender identity (optional): Transgender Male Transgender Female Non-binary Prefer not to say Prefer to self-describe: _____

Is dependent a full-time student over age 19? Yes No Married? No Yes Expected Graduation Date: _____
 If yes, please provide name of college/university: _____ Will dependent further education after graduation? Yes No

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 or addendum if more than three dependents need coverage

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? Yes No
 If yes, what type of coverage? Medical Dental
 What is the effective date of the other coverage? Medical: _____ Dental: _____
 What is the name of the other carrier? _____
 Are you keeping the coverage? Yes No
 If no, when will the coverage end? Medical: _____ Dental: _____
 Policyholder's name _____ ID#(s) _____
 Who did the insurance cover? Self Only Self & Spouse/Domestic Partner Self & Child(ren) Family

Section 7: 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.
 Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.
HEALTH MAINTENANCE ORGANIZATION (HMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. **POINT OF SERVICE (POS)** I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.

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 P.O. Box 21146 Eagan, MN 55121-0146
 If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Only complete if other coverage is applicable.

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information
 This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.

Section 2: Subscriber's Information
 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. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 3: Reason for enrollment or change
 Select the box(es) that describe(s) the reason for this enrollment or change 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. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?
 If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)
 Please include information about all the people who you would like coverage for.
 Use an additional application or addendum if more than three dependents 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 county clerk)
- 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 disabled dependent who is over the maximum 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.
 * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.
 A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

Section 6: Other coverage information (Required)
 Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
 Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

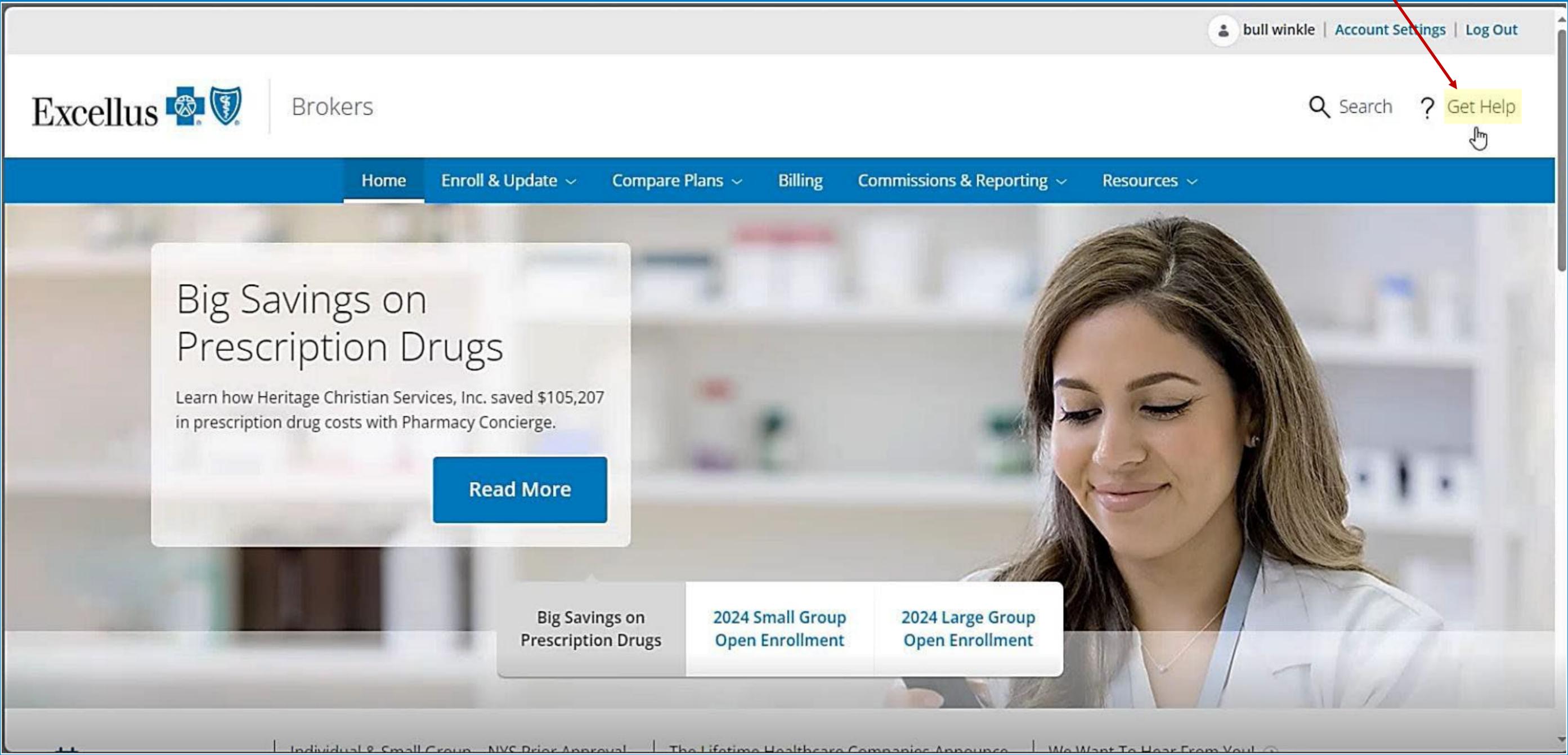
How to Access the Enrollment Inquiry & Support Dashboard

Visit www.excellusbcbs.com

Click "Login/Register"

The screenshot shows the homepage of the Excellus BCBS website. At the top, there is a navigation bar with links for Home, Members, Medicare Members, Employers, Brokers, and Providers. Below this is the Excellus logo and a search bar with a 'Search' icon, a 'Get Help' link with a question mark icon, and a 'Login/Register' button. A red arrow points from the text 'Click "Login/Register"' to this button. Below the navigation bar is a blue header with links for Home, Find a Plan, How it Works, Find a Doctor, and Health and Wellness. A light blue banner below the header contains the text: 'Need care? Understand your care options and find the right doctor for you.' The main content area features a large image of a woman with curly hair looking at her smartphone. Overlaid on this image is a white box with the text 'Explore Your Benefits' and 'Log in to your account 24/7.' Below this text is a blue button that says 'Download Our Mobile App'. At the bottom of the image area, there is a white bar with four buttons: 'Explore Your Benefits', 'Plans for Everyone', 'Meet Our Medical Directors', and 'Ranked Among Best Employers'.

Click "Get Help" in the top right-hand corner



Click "Enrollment Inquiry & Support Tool"

Excellus  Brokers

Account Settings | Log Out

Search ? Get Help

Home | **Enroll & Update** | Compare Plans | Billing | Commissions & Reporting | Resources

Brokers > Contact Us

Contact Us

Email | Phone | Mail

Follow these links to send a private, secure message to us. Our representatives will respond within **four business days**. If you need an immediate response, please call by telephone.

[Enrollment Inquiry & Support Tool](#)

- ① Log in and use the Enrollment & Inquiry Support tool to send all inquiries to our Enrollment team. SSL encryption ensures that the information transmitted remains secure.
- ① Check Out Our Process for Enrollment Inquiry & Support

If you do not have a login today, it's easy to request one:

- Go to broker.excellusbcbs.com/registration
- Select the appropriate option
- Complete all fields; click 'Submit'

To access a tip, click “Enrollment Inquiry & Support

Home Enroll & Update Compare Plans Billing Commissions & Reporting Resources

Brokers > Contact Us

Contact Us

Email Phone Mail

Follow these links to send a private, secure message to us. Our representatives will respond within **four business days**. If you need an Enrollment Inquiry & Support Tool

- 1 Log in and use the Enrollment & Inquiry Support tool to send all inquiries to our Enrollment team. SSL encryption ensures that the information is secure.
- 2 Check Out Our Process for Enrollment Inquiry & Support

If you do not have a login today, it's easy to request one:

- Go to broker.excellusbcb.com/registration
- Select the appropriate option
- Complete all fields; click 'Submit'
- Your request will be completed within 24-48 hours

- General Broker Inquiries
- Add or Remove Group Numbers for Online Enrollment & Billing
- Prescription Drug Help Desk

ENROLLMENT INQUIRY SUPPORT TOOL PROCESS

Tips on how to use the process

The purpose of this tool is to streamline all your eligibility maintenance requests, enrollment inquiries, billing/reconciliation requests, and other support requests. By submitting your inquiries and requests via this tool, they are securely transmitted directly to the request management system that is utilized to assign and process requests within our Enrollment department.

Security

You will need to log in prior to using the Enrollment inquiry & Support tool. When submitting requests, the tool will auto populate certain fields based on the user's profile. The form itself utilizes Secure Sockets Layer (SSL) technology (the industry standard for secure transactions) to transmit the information to our request management system.

Completing the Form

The most common reason for an inquiry is likely to be Eligibility Maintenance. This reason for inquiry should be chosen for subscriber/member activity, new enrollments, and member additions to an existing contract, changes, terminations, etc. All appropriate paperwork must accompany the request and required fields must be completed. If retroactive review is required, please reference the Retroactive Process Tip Sheet, and include a completed Exception Request Form.

Attachments

Please be sure that all selected attachments are uploaded to the request prior to clicking the "agree and submit" button. Attach your documentation. Depending on the browser and version being used, attachment functionality may vary slightly. Web browsers such as Google Chrome allow multiple attachments to be submitted on the same request. Certain browsers may only allow one attachment. If your browser has an "upload" button, be sure to fully upload the attachments to the item.

Creating a New Case

The Dashboard can be used to locate previously submitted cases and create new requests.

To Create a New Case

The system automatically defaults to 90 days. These dates can be changed to access previously submitted cases beyond 90 days.

TIP:
The Status is in real time. If you would like to refresh, click the blue "Search" button.

Use the Search bar to enter keywords.

Below is the form that will appear after clicking “+ Create a New Case” you will be brought to this page. Fill out the required fields (*).

FORM

[Return to Previous Page](#)

*** Required Fields**

Please provide as much information as you can then click 'Agree and Submit' at the bottom of the form. We protect the privacy of your message with SSL Encryption [\[i\]](#).

Your Name *

Your Phone * **Extension**
Your Email *
Your Role *

Group Administrator Broker of Record

Case For *

Individual Market Employer Group Market

Market Segment *

Case For: Employer Group Market

Select Your Role option based on your applicable role as either the Group Administrator or Broker of Record

In the Case For field select Employer Group Market.

In the Market Segment field select either “Commercial Group Health Insurance” or “Medicare Employer/Union Group Health Plan”

NOTE: In the Case For field Individual Market is for direct pay plans only. Employer groups should not be using this option. It is an option for our Brokers of Record when enrolling through the Exchange. In these instances, the option to select under Market Segment would be Qualified Health Plan Individual & Family Health Insurance

Your Role *

Group Administrator Broker of Record

Case For *

Individual Market Employer Group Market

Market Segment *

Commercial Group Health Insurance

-Please Select-

Qualified Health Plan Individual & Family Health Insurance

Commercial Group Health Insurance

Medicare Employer/Union Group Health Plan

Group Number(s) *

Market Segment: Commercial Group Health Insurance

The screenshot shows the Excellus web portal interface. At the top, there is a navigation bar with the Excellus logo and links for Home, Enroll & Update, Compare Plans, Billing, Commissions & Reporting, and Resources. Below the navigation bar, there are several form fields: 'Your Email' (chinmay.joshi@excellus.com), 'Your Role' (Group Administrator, Broker of Record), 'Case For' (Individual Market, Employer Group Market), 'Market Segment' (dropdown menu), 'Group Number(s)', 'Group Number not listed', 'Subscriber First Name', and 'Subscriber Last Name'. The 'Market Segment' dropdown menu is open, showing options: '-Please Select-', '-Please Select-', 'Commercial Group Health Insurance', and 'Medicare Employer/Union Group Health Plan'. A red box highlights the 'Market Segment' dropdown menu and the text 'Select Commercial Group Health Insurance under Market Segment'. Another red box highlights the 'Reason for Inquiry' dropdown menu and the text 'Then select the Reason for Inquiry from the dropdown.'.

Select Commercial Group Health Insurance under Market Segment

Then select the Reason for Inquiry from the dropdown.

This is a close-up view of the 'Reason for Inquiry' dropdown menu. The dropdown is open, showing options: '-Please Select-', '-Please Select-', 'Eligibility Maintenance', 'Billing and Reconciliation', and 'Request ID Card'. A mouse cursor is hovering over the 'Eligibility Maintenance' option. To the right of the dropdown menu, there is a 'View Details' link with an information icon.

Commercial Group Health Insurance

Reason for Inquiry:

Eligibility Maintenance

Action Needed: Add new subscriber/policyholder

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Add new subscriber/policyholder

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name * ? **Subscriber Last Name ***
 Subscriber First Name ? Subscriber Last Name ?

Plan(s) **Action Effective Date ***

Medical MM-DD-YYYY 📅

Dental MM-DD-YYYY 📅

RX Only MM-DD-YYYY 📅

Vision MM-DD-YYYY 📅

If the group number does not appear in the listing, manually add it under "Group Number not listed." Ability to add up to four (4) group numbers.

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name	Group Number
Effective Date	Subscriber Name
Subscriber DOB	Subscriber Gender
Plan Selection	Class
Subgroup	Qualifying Event
Dependent Information <ul style="list-style-type: none"> • Dependent Name • Dependent Gender • Dependent DOB 	Relationship
Other Coverage Information (If applicable)	Group Administrator Signature
Subscriber Signature	

Action Needed: Add or change coverage for a dependent

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Add or change coverage for a dependent

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name * ?
 Subscriber First Name

Subscriber Last Name *
 Subscriber Last Name

Action Effective Date *

Subscriber ID * +
 Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or visio

Dependent First Name *
 Dependent First Name

Dependent Last Name *
 Dependent Last Name

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Effective Date	Reason for Adding
Subscriber Information	Dependent Information (only required to list dependent being added)
Group Administrator Signature	Subscriber Signature

Action Needed: Reinstate or re-enroll a cancelled/termed policy

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Reinstate or re-enroll a cancelled/termed policy

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
 Subscriber First Name

Subscriber Last Name
 Subscriber Last Name

Plan(s)

- Medical
- Dental
- RX Only
- Vision

Action Effective Date *

MM-DD-YYYY 📅

MM-DD-YYYY 📅

MM-DD-YYYY 📅

MM-DD-YYYY 📅

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Qualifying Event
Subscriber ID or Name	Effective Date
Group Name	Group Number

Action Needed: Cancel/terminate a subscriber/policyholder

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Effective Date *
MM-DD-YYYY 📅

Subscriber ID * +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *
Cancel/terminate a subscriber/policyholder

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name or Number	Cancel Effective Date
Subscriber SSN or ID	Subscriber Name
Group Administrator Signature	

Action Needed: Cancel/terminate a dependent

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Cancel/terminate a dependent

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name * ?
 Subscriber First Name

Subscriber Last Name *
 Subscriber Last Name

Action Effective Date *
 MM-DD-YYYY 📅

Subscriber ID * +
 Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional sub

Dependent First Name *
 Dependent First Name

Dependent Last Name * +
 Dependent Last Name

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Effective Date	Reason for Terming
Subscriber Information	Dependent Information (only required to list dependent being termed)
Subscriber Signature	

Action Needed: Update demographic data for an existing member

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Update demographic data for an existing member

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
 Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
 Subscriber First Name

Subscriber Last Name
 Subscriber Last Name

Action Effective Date *
 MM-DD-YYYY 📅

Subscriber ID * +
 Subscriber ID
 Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Address Change	<ul style="list-style-type: none"> New address Subscriber Information
Subscriber Name Change	<ul style="list-style-type: none"> Subscriber Information (including name change)
Dependent Name Change	<ul style="list-style-type: none"> Subscriber Information Dependent Information (including name change)
Birth Date Changes	<ul style="list-style-type: none"> Subscriber Information (if applicable) Dependent Information (if applicable)
Gender Changes	<ul style="list-style-type: none"> Subscriber Information (if applicable) Dependent Information (if applicable)

Action Needed: Move to COBRA

Reason for Inquiry *

Eligibility Maintenance View Details

Group Number(s) *

Search Group Number

Group Number not listed ? +

Enter Group Number

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name

Subscriber First Name

Subscriber Last Name

Subscriber Last Name

Action Effective Date *

MM-DD-YYYY 📅

Subscriber ID * +

Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *

Move to COBRA

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Subscriber Signature
Effective Date	Subscriber ID or Name
Group Name or Number	Subgroup
Class	

Action Needed: Add multiple new members to the same employer

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Add multiple new members to the same employer

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name	Group Number
Effective Date	Subscriber Name
Subscriber DOB	Subscriber Gender
Plan Selection	Class
Subgroup	Qualifying Event
Dependent Information <ul style="list-style-type: none"> • Dependent Name • Dependent Gender • Dependent DOB 	Other Coverage Information (If applicable)
Relationship	Group Administrator Signature
Subscriber Signature	

Application needed for each member being added to the same employer group.

Action Needed: Update multiple members of the same employer

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Action Needed *
Update multiple members of the same employer

Note: Please fill out all fields that include *

Required fields depend on what needs to be updated

Action Needed: Cancel/terminate multiple members of the same employer

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional e

Action Needed *
Cancel/terminate multiple members of the same employer

The Action Needed requires these elements when filling out the paper Enrollment Application or the cancellation worksheet being attached as long as all from same group:

For each member being canceled from the same employer group

Group Name or Number	Cancel Effective Date
Subscriber SSN or ID	Subscriber Name
Group Administrator Signature	

Action Needed: Change plan

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Effective Date *
MM-DD-YYYY 📅

Subscriber ID * +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *
Change plan

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Subscriber Signature
Effective Date	Subscriber ID or Name
Group Name or Number	

Action Needed: I need help with something else

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Effective Date *
MM-DD-YYYY 📅

Subscriber ID * +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *
I need help with something else

Note: Please fill out all fields that include *

Commercial Group Health Insurance

Reason for Inquiry:

Billing and Reconciliation

Action Needed: Question on my invoice

Reason for Inquiry *
Billing and Reconciliation View Details

Action Needed *
Question on my invoice

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Billing Month * MM **Billing Year *** YYYY

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Action Needed: Correct a payment allocation

Reason for Inquiry *
Billing and Reconciliation View Details

Action Needed *
Correct a payment allocation

Group Number(s) *
Search Group Number

Group Number not listed +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Payment Date * **Payment Amount**
MM-DD-YYYY 📅 \$

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Action Needed: Request a refund

Reason for Inquiry *
Billing and Reconciliation ⌵ [View Details](#)

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name ⌵

Subscriber Last Name
Subscriber Last Name ⌵

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *
Request a refund ⌵

Note: Please fill out all fields that include *

Action Needed: Request a copy of an invoice

Reason for Inquiry *
Billing and Reconciliation View Details

Action Needed *
Request a copy of an invoice

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Billing Month * **Billing Year ***
MM YYYY

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Action Needed: Request a rebill

Reason for Inquiry *
Billing and Reconciliation

Action Needed *
Request a rebill

Group Number(s) *

Group Number not listed ?

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber Last Name

Billing Month *
Billing Year *

Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Commercial Group Health Insurance

Reason for Inquiry:

Request Member ID Card

Action Needed: Request an ID Card

Reason for Inquiry *
Request ID Card View Details

Action Needed *
Request an ID card

Group Number(s) *
Search Group Number

Group Number not listed +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Subscriber ID +
Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Market Segment: Medicare Employer/Union Group Health Plan

Your Email *
chinmay.joshi@excellus.com

Your Role *
 Group Administrator Broker of Record

Case For *
 Individual Market Employer Group Market

Market Segment *
-Please Select-
-Please Select-
Commercial Group Health Insurance
Medicare Employer/Union Group Health Plan

Group Number(s) *
Search Group Number

Group Number not listed +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Needed *
-Please Select-

Reason for Inquiry *
-Please Select-
Eligibility Maintenance
Billing and Reconciliation

[View Details](#)

Select the Reason for Inquiry from the dropdown.

Select Medicare Employer/Union Group Health Plan under Market Segment

Medicare Employer / Union Group

Reason for Inquiry:

Eligibility Maintenance

Action Needed: Add new subscriber/policyholder

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Add new subscriber/policyholder

Group Number(s) *
 Search Group Number

Group Number not listed +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name * ? **Subscriber Last Name ***
 Subscriber First Name ⌵ Subscriber Last Name

Plan(s) **Action Effective Date ***

Medical MM-DD-YYYY 📅

RX Only MM-DD-YYYY 📅

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name	Group Number
Effective Date	Subscriber Name
Subscriber DOB	Subscriber Gender
Plan Selection	Class
Subgroup	Qualifying Event
Dependent Information <ul style="list-style-type: none"> • Dependent Name • Dependent Gender • Dependent DOB 	Relationship
Other Coverage Information (If applicable)	Group Administrator Signature
Subscriber Signature	

Action Needed: Reinstate or re-enroll a cancelled/termed policy

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Reinstate or re-enroll a cancelled/termed policy

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
 Subscriber First Name

Subscriber Last Name
 Subscriber Last Name

Plan(s)
 Medical
 RX Only

Action Effective Date *
 MM-DD-YYYY 📅
 MM-DD-YYYY 📅

Subscriber ID +
 Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Qualifying Event
Subscriber ID or Name	Effective Date
Group Name	Group Number

Action Needed: Cancel/terminate a subscriber/policyholder

Reason for Inquiry *
Eligibility Maintenance View Details

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Effective Date *
MM-DD-YYYY 📅

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Action Needed *
Cancel/terminate a subscriber/policyholder

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name or Number	Cancel Effective Date
Subscriber SSN or ID	Subscriber Name
Group Administrator Signature	

Action Needed: Update demographic data for an existing member

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Update demographic data for an existing member

Group Number(s) *
 Search Group Number

Group Number not listed +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
 Subscriber First Name

Subscriber Last Name
 Subscriber Last Name

Action Effective Date *
 MM-DD-YYYY

Subscriber ID +
 Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or vision policy

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Address Change	<ul style="list-style-type: none"> New address Subscriber Information
Subscriber Name Change	<ul style="list-style-type: none"> Subscriber Information (including name change)
Dependent Name Change	<ul style="list-style-type: none"> Subscriber Information Dependent Information (including name change)
Birth Date Changes	<ul style="list-style-type: none"> Subscriber Information (if applicable) Dependent Information (if applicable)
Gender Changes	<ul style="list-style-type: none"> Subscriber Information (if applicable) Dependent Information (if applicable)

Action Needed: Add multiple new members to the same employer

Reason for Inquiry *
Eligibility Maintenance

Group Number(s) *

Group Number not listed ?

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Action Needed *
Add multiple new members to the same employer

Note: Please fill out all fields that include *

Action Needed: Update multiple members of the same employer

Reason for Inquiry *
Eligibility Maintenance ⌵ [View Details](#)

Group Number(s) *

Group Number not listed [?](#) +

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Action Needed *
Update multiple members of the same employer ⌵

Note: Please fill out all fields that include *

Action Needed: Change plan

Reason for Inquiry *
 Eligibility Maintenance View Details

Action Needed *
 Change plan

Group Number(s) *
 Search Group Number

Group Number not listed ? +
 Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
 Subscriber First Name

Subscriber Last Name
 Subscriber Last Name

Action Effective Date *
 MM-DD-YYYY 📅

Subscriber ID +
 Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Subscriber Signature
Effective Date	Subscriber ID or Name
Group Name or Number	

Action Needed: I need help with something else

Reason for Inquiry *
Eligibility Maintenance View Details

Action Needed *
I need help with something else

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Action Effective Date *
MM-DD-YYYY

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Medicare Employer / Union Group

Reason for Inquiry:

Billing and Reconciliation

Action Needed: Question on my invoice

Reason for Inquiry * Billing and Reconciliation [View Details](#)

Action Needed * Question on my invoice

Group Number(s) * Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name Subscriber First Name

Subscriber Last Name Subscriber Last Name

Billing Month * MM **Billing Year *** YYYY

Subscriber ID +
Subscriber ID

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Action Needed: Correct a payment allocation

Reason for Inquiry *
Billing and Reconciliation

Action Needed *
Correct a payment allocation

Group Number(s) *

Group Number not listed

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name

Subscriber Last Name

Payment Date *
Payment Amount

Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Action Needed: Request a refund

Reason for Inquiry *
Billing and Reconciliation View Details

Action Needed *
Request a refund

Group Number(s) *
Search Group Number

Group Number not listed ? +
Enter Group Number
Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

Subscriber First Name
Subscriber First Name

Subscriber Last Name
Subscriber Last Name

Subscriber ID +
Subscriber ID
Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

Note: Please fill out all fields that include *

Submitting a Case

Submitting a Case

Attach files if needed based on the information provided under Table of Forms section.

Attach Files Below

Click "Select" to browse and add your documentation. Accepted file types: .pdf, .doc, .docx, .jpeg, .xls, .tiff

Documents Attached *

Yes No

Attached Document * ? +

Select

Additional Details

Agree and Submit Cancel Print

Printing a copy of request is available.

When finished, click "Agree and Submit"

Submitting a Case

Once the case is submitted, you will be redirected to the Enrollment Inquiry & Support dashboard.

The screenshot displays the 'Enrollment Inquiry & Support' dashboard for a user named 'bull winkle'. At the top, there is a navigation bar with 'Home', 'Enroll & Update', 'Compare Plans', 'Billing', 'Commissions & Reporting', and 'Resources'. Below this, a breadcrumb trail shows 'Brokers > Contact Us > Enrollment Inquiry & Support'. The main heading is 'Enrollment Inquiry & Support'. A green notification banner states: 'Your case has been submitted successfully. Your case ID is ENR-149001. If you have any questions regarding your case, please contact your dedicated Account Service Consultant.' A red box highlights this message with the text 'This is where you can locate the Case ID.' Below the notification is a 'DASHBOARD' section with the same message and a '+ Create New Case' button. At the bottom, there is a 'My Cases' section with filters for 'From' (03-16-2024) and 'To' (06-14-2024), and a 'Search' button. A red box highlights the 'Search' button with the text 'WARNING: Clicking the refresh button at the top of the page will create duplicates. To see the updates in the Enrollment Inquiry & Support dashboard, click the "Search" button.'

