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For Internal Use Only	
HIOS ID#:	78124NY1000105-00
EC:	SDK5

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

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	

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

Group Administrator's Signature _____ Date _____

Subscriber Status:

Date of Hire: ___/___/___

Rehire - Date of Rehire: ___/___/___ Retired - Effective Date: ___/___/___

COBRA - Effective Date: ___/___/___ Cancelled -- Effective Date: ___/___/___

Please indicate reason for COBRA if applicable:

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

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 _____ Would you like to receive emails about health & wellness? Yes No

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

SimplyBlue Plus Silver 4

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:

- Dental Blue Classic (DI) Dental Blue Options (DJ)
 Dental Other (DE)

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

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

Medical & Dental Effective Date: ___/___/___

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.

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 _____

Date of Event: ___/___/___**Section 6: If canceling coverage, who are you canceling coverage for?**

- Subscriber
 Medical Cancellation Date ___/___/___ Dental Cancellation Date ___/___/___
 Dependent(s) (List each dependent below in section 8)
 Medical Cancellation Date ___/___/___ Dental Cancellation Date ___/___/___

Why are you canceling coverage?

- Subscriber's request Divorce Deceased Medicare/Medicaid or other coverage
 Coverage through spouse 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 #: _____

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 #: _____

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 #

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: ___/___/___

Dependent Child Disabled Dependent Child*Separate form required Other _____

Sex: M F Birthdate ___/___/_____

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

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: ___/___/___

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

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.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

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