344 S. Warren St., Syracuse, New York 13221
A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM

DO NOT USE - MICROFILM ONLY

Instructions on Back. All Dates = mm/dd/yy ☐ Check if name change ☐ Check if new address Please print clearly using Blue Ink.

✓ CHECK DESIRED ACTION | **✓ CHECK DESIRED COVERAGE - Select One Product Option** | **✓ CHECK PERSON(S) COVERED**

☐ **Add** Subscriber (AA)
Date of Hire/Event ___/___/___
Coverage Eff Date ___/___/___

☐ **Add** Dependent (AB)
Date of Event ___/___/___
Coverage Eff Date ___/___/___

☐ **Change** Coverage (AC)
Coverage Eff Date ___/___/___

☐ BluePoint (BT)
☐ BluePoint 2 (SF)
☐ Blue PPO (BP)
☐ Blue EPO (BE)
☐ BluePreferred PPO (PN)
☐ BCBS Traditional (TR)
☐ BCBS Comprehensive (CO)
☐ BCBS WRAPAROUND (WR)

☐ HMO Blue (MO)
☐ HMO Blue Value (HB)
☐ HMO Blue Essential (BL)
☐ HMO Blue 25 (MZ)
☐ Senior Ins. High Option (SH)
☐ Secure Comp (SC)
☐ Blue EPO Balance (UE)
☐ BluePPO Savings Account Plan (DC)

	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
MEDICAL	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
VISION	☐	☐	☐	☐
DRUG	☐	☐	☐	☐

✓ CHECK DESIRED COVERAGE
☐ Dental **(DE)** ________ ☐ Dental Blue PPO **(OL)** ☐ Vision **(VI)** ☐ Drug **(RX)**

☐ **Transfer** to COBRA (AD)
☐ (S)ubscriber ☐ (D)isabled
☐ (M) Dependent
Date of Event ___/___/___

☐ **Cancel** Subscriber (S)
☐ **Cancel** Dependent (M)
☐ (M)edical ☐ (V)ision ☐ (D)rug
☐ (D)ental
Reason Code_______(See back)
Cancellation Date ___/___/___
If Reason Code SD Or DM,indicate
Date of Death ___/___/___

SUBSCRIBER INFORMATION - Must be completed
Social Security # _______-_______-___________ Sex: ☐ M ☐ F Birthdate: ______________
Last Name_________________________________ First_________________________
Street____
City_______________________________ State______________ Zip____________
Day Phone:____________________ E-Mail Address:____________________
Do you have Medicare? ☐ Yes ☐ No If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim No.: Medicare Part A Eff Date: Medicare Part B Eff Date:

BluePoint, Blue Point 2 and HMOBlue Members must select a Health Center or Primary Care Physician (PCP)
✓Check Medical Center: ☐ [H] Health Center East ☐ [C] Central Square
Primary Care Physician (Last)______________ (First)______________ Current patient? ☐ Y☐ N
BluePoint 2 members may select an Obstetrician or Gynecologist
OB/GYN Physician (Last)______________ (First)______________ Current patient? ☐ Y☐ N

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

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other ______________
☐ Student (T) ☐ Full-time ☐ Part-time Graduation Date: ______________
School Name:
Social Security Number # _______-_______-___________
Sex: ☐ M ☐ F Birthdate: ______________
Last Name (if different):______________ **First Name:**______________

✓Check Medical Center: ☐ [H] Health Center East ☐ [C] Central Square
Primary Care Physician Current patient? ☐ Y☐ N
Last ______________ First ______________
OB/GYN Provider Current patient? ☐ Y☐ N
Last ______________ First ______________
Enrolled with Medicare? ☐Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim No.:
Medicare Part A Eff Date: Medicare Part B Eff Date:

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other ______________
☐ Student (T) ☐ Full-time ☐ Part-time Graduation Date: ______________
School Name:
Social Security Number # _______-_______-___________
Sex: ☐ M ☐ F Birthdate: ______________
Last Name (if different):______________ **First Name:**______________

✓Check Medical Center: ☐ [H] Health Center East ☐ [C] Central Square
Primary Care Physician Current patient? ☐ Y☐ N
Last ______________ First ______________
OB/GYN Provider Current patient? ☐ Y☐ N
Last ______________ First ______________
Enrolled with Medicare? ☐Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim No.:
Medicare Part A Eff Date: Medicare Part B Eff Date:

☐ (S)pouse ☐ (D)ependent ☐ (H) Disabled Dependent ☐ Other ______________
☐ Student (T) ☐ Full-time ☐ Part-time Graduation Date: ______________
School Name:
Social Security Number # _______-_______-___________
Sex: ☐ M ☐ F Birthdate: ______________
Last Name (if different):______________ **First Name:**______________

✓Check Medical Center: ☐ [H] Health Center East ☐ [C] Central Square
Primary Care Physician Current patient? ☐ Y☐ N
Last ______________ First ______________
OB/GYN Provider Current patient? ☐ Y☐ N
Last ______________ First ______________
Enrolled with Medicare? ☐Y ☐ N If yes, indicate reason: ☐ Age ☐ Disabled ☐ ESRD
Medicare Claim No.:
Medicare Part A Eff Date: Medicare Part B Eff Date:

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information. In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer. Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)? ☐ Yes☐ No✓ Check: ☐ Medical and/or ☐ Dental Are you keeping this coverage? ☐ Yes ☐ No If No, indicate cancel date ___/___/___
Policyholder's Name______________________ Effective Date: ___/___/___ Did this insurance cover ☐ Insured ☐ Insured and Family
✓ Check previous insurance company from list below and indicate ID #:______________________
☐ (B) Excellus BlueCross BlueShield
☐ (O) Other - BlueCross BlueShield Plan. Indicate Plan Name: ______________________
☐ (C) Other Carrier - Indicate Plan Name:______________________

RELEASE - You must sign and date this form to be eligible for insurance.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back. **Subscriber Signature** ______________________________ **Date**______________

EMPLOYER INFORMATION (Must be completed by Group Representative) Shaded areas are optional.

Coverage	Group/Sub Group #		Chk Digit	Pkg #	Employer Name:
Medical					Employee Status ☐ (A) Active ☐ (A) COBRA ☐ (A) Termination ☐ (R) Retired
Dental					Payroll Location # Employee #
Drug					**Group Rep Signature** **Date**
Vision					

Instructions for completing the Group Enrollment Form

DESIRED ACTION - Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Representative for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request
To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision, Drug)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons ***NonGroup Conversion Information will be mailed.**

*LE- Left Employer/No Longer(11)

SD - Subscriber Deceased (05)
SR - Subscriber Request (02)
CB - COBRA Begin Date
CD - COBRA Disabled Date
TT – Transfer to Traditional

*CE - COBRA End Date (29)
TH – Transfer to HMO (73)
CP – Commercial (09)
SB - Spouse's Excellus BCBS
MC – Medicaid
TP – Transfer to POS (73)
MX – Medicare (03)

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision, Drug)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA – Marriage (28)
OA - Dependent Over Age (20)
DM – Deceased (05)
MS – Ineligible Student (28)

MB - COBRA Begin Date
MR - Subscriber Request (02)
DV – Divorce (25)
MX – Medicare (03)

If the only change is one of the following, please call Customer Service at the telephone number indicated on your identification card. A Group Enrollment Form is not required.
- Address
- Birthdate
- PCP

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Entitlement.

FAMILY MEMBER Use an additional form, if more than three persons.
QUALIFIED GUIDELINES:
- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Unmarried eligible dependents who are chiefly dependent on you for support. (Must be under the dependent/student age for your employer group, unless certified by us as an incapable of self-sustaining employment.)

- Biological children
- Children of your spouse
- Children for whom you are legal guardian
- Your adopted children
- Children who have been placed with you for adoption

RELEASE
- I am applying to enroll myself and my eligible dependents, if any, under the contract and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

The certificate or contract for which application is being made may impose a waiting period of up to 330 days for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Representative.
Complete only the coverage section (Medical, Dental, Vision, Drug) that is applicable to the employee's request.