

P.O. Box 22999, Rochester, NY 14692  
 A nonprofit independent licensee of the BlueCross BlueShield Association

**Tompkins County**  
**GROUP ENROLLMENT FORM**

HIOS ID# \_\_\_\_\_  
 EC \_\_\_\_\_

**1 - Group Employer Information**

PLEASE PRINT CLEARLY

This section should be completed by the Group Benefits Administrator.  
 This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

**Group #**                          Subgroup #                  Class#  
 00036755                      [ ][ ][ ][ ][ ]                  [ ][ ][ ][ ][ ]

**Employer Name**  
 Tompkins County

Association/Chamber Name (if applicable)

Group Administrator Signature/Date  
 X

**Subscriber Status:**  
 Active     Retired     COBRA     Cancelled

**Please indicate reason for COBRA:**  
 Left Employment/Retirement     Death of Spouse  
 Divorce/Legal Separation     Dependent Reached Max Age  
 Other \_\_\_\_\_

Effective Date                      COBRA Effective Date  
 [ ][ ][ ][ ][ ][ ][ ]                      [ ][ ][ ][ ][ ][ ][ ]

Hire/Rehire Date                      Retired Effective Date  
 [ ][ ][ ][ ][ ][ ][ ]                      [ ][ ][ ][ ][ ][ ][ ]

**2 - Subscriber Plan Selection**

Department # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]    Employee # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Please use blue or black ink, print one character per box. Check applicable plan(s).

<input type="checkbox"/> Classic Blue (BFZ) <input type="checkbox"/> Classic Blue (BGG) <input type="checkbox"/> Classic Blue (BFI) <input type="checkbox"/> Classic Blue (BFK) <input type="checkbox"/> Classic Blue (BFL)  <input type="checkbox"/> SB (DAA) Platinum	<input type="checkbox"/> PPO \$10 (BET) <input type="checkbox"/> PPO \$10 (BEV) <input type="checkbox"/> PPO \$10 (BEW)  <input type="checkbox"/> COMP- Value Plan (BEL)	Please check coverage type and person(s) to be covered: <input type="checkbox"/> Medical <input type="checkbox"/> single <input type="checkbox"/> family
---	--	---

**3 - Reason for Enrollment/Change**

Subscriber, please indicate the reason for this enrollment or change.

<input type="checkbox"/> New Hire	<input type="checkbox"/> COBRA	<input type="checkbox"/> Retirement	<input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Domestic Partner
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Address/Phone Number	<input type="checkbox"/> Last Name	<input type="checkbox"/> Age 65+	<input type="checkbox"/> Remove Dependent
<input type="checkbox"/> Medicare Eligible / Please indicate reason for Medicare eligibility:	<input type="checkbox"/> Newborn	<input type="checkbox"/> Disability	<input type="checkbox"/> End Stage Renal Disease	
<input type="checkbox"/> Add Dependent / Please indicate reason for adding dependent:	<input type="checkbox"/> Adoption	<input type="checkbox"/> Marriage	<input type="checkbox"/> Marital Status Change	

**4 - Subscriber Information**

Please complete both sides of this application.  
 The subscriber signature is required in order to process the application.

Subscriber's Last Name                      Subscriber's First Name

[ ]    [ ]

Middle Initial    Title                  E-mail Address

[ ][ ]    [ ][ ][ ]                  [ ]

Mailing Address    Apt or Suite

[ ]    [ ][ ][ ][ ][ ]

City    State                  Zip

[ ]    [ ][ ]    [ ][ ][ ][ ][ ]

Work Phone Number                  Home Phone Number                  Cell Phone Number

[ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ][ ]/[ ][ ][ ][ ]-[ ][ ][ ][ ]-[ ][ ][ ][ ]/[ ][ ][ ]-[ ][ ][ ][ ]-[ ][ ][ ][ ]

Date of Birth                  Gender                  Social Security Number

[ ][ ][ ][ ][ ][ ]    [ ] M [ ] F                  [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ][ ]

Marital Status:  Single  Married  Legally Separated  Divorced/ Marital Status Event Date

Medicare Number (if applicable)   
Part A Effective Date   
Part B Effective Date

If Medicare eligible due to ESRD please check type of dialysis:  Self administered  Facilitated Date started

**5 – Other Coverage Information** Have you ever been a member of Excellus BlueCross BlueShield?  Yes  No  
**In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.**

Are you or any member of your family enrolled in any other health [or dental] insurance policy (including Medicare or Medicaid)? Health?  No  Yes

If answering "Yes", are you keeping the additional health coverage? Health?  No  Yes

Who did the other plan cover?  Self  Spouse  Children

Other insurance carrier name: \_\_\_\_\_  
Other insurance name of policyholder: \_\_\_\_\_

Policy ID Number:   
Effective Date   
Termination Date

**6 – Cancellation Information**  
**Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).**

Subscriber  Medical /Reason \_\_\_\_\_ Date

Dependent (list each dependent in section 7)  
 Medical / Reason \_\_\_\_\_ Date

**7 – Dependent Information**  
**Please provide all information for each person to be covered.**

Subscriber's Last Name   
Subscriber's First Name

Spouse/[Domestic Partner] Last Name   
Spouse/[Domestic Partner] First Name   
M.I.

Male Date of Birth   
 Female \_\_\_\_\_  
Social Security Number --  
Are you enrolling as a Domestic Partner?  Yes  No

Medicare Number (if applicable)   
Part A Effective Date   
Part B Effective Date

Subscriber's Last Name   
Subscriber's First Name

Dependent's Last Name   
Dependent's First Name   
M.I.

Male Date of Birth   
 Female \_\_\_\_\_  
Social Security Number --  
Is your over-age dependent handicapped or disabled?  Yes  No  
(See last page for additional information)

**8 – Release/Signature**  
**Subscriber signature required. 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 \_\_\_\_\_



Tompkins County
GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

9 - Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name, Subscriber's First Name, Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number, Is your over-age dependent handicapped or disabled? Yes/No

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number, Is your over-age dependent handicapped or disabled? Yes/No

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number, Is your over-age dependent handicapped or disabled? Yes/No

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number, Is your over-age dependent handicapped or disabled? Yes/No

Dependent's Last Name, Dependent's First Name, M.I., Male, Date of Birth, Social Security Number, Is your over-age dependent handicapped or disabled? Yes/No

## Instruction Page

**Reason for Enrollment/Change:** Check the appropriate action in the space provided. 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/Representative 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.

### Cancel Request

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

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### Cancel Subscriber Reasons

Left Employer/No Longer Eligible Commercial	COBRA End Date
COBRA Begin Date	Subscriber Request
COBRA Handicapped/Disabled Date	Subscriber Deceased
Transfer to Traditional	Spouse's Insurance
Transfer to HMO	Medicaid
Transfer to POS	Medicare

#### To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

#### Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
	Medicare

**COVERAGE TYPE** All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

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

**FAMILY MEMBER INFORMATION** If there are more than seven dependents please use an additional form.

#### QUALIFIED GUIDELINES:

- A legal spouse (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:
  - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

**Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.**

#### RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical 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.

#### 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 an out-of-network benefit which 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.

**GROUP EMPLOYER INFORMATION** This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:

**1-800-499-1275** Or, visit us at:

[www.excellusbcbs.com](http://www.excellusbcbs.com)