

| DO NOT USE – FOR INTERNAL PURPOSES ONLY | |
|---|--|
| HIOS ID# | |
| | |

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

Town of Cuyler

| 1 – Group Employ | ge. All Dates = mm/dd/yy | GROUP ENRO | LLMÉNT FORM | PLEASE PRINT CLEARLY |
|--|--|---|---|-------------------------------------|
| This section should | ld be completed by the | | | |
| | annot be processed wit k ink, print one character per b | | ion and a signature. Subscriber Status: | |
| Group# | Subgroup# | Class# | Active Retire | d COBRA Cancelled |
| 00123209 | | | ase indicate reason for COBRA | <u> </u> |
| Employer Name | | | Left Employ/Retirem | ent Death of Spouse |
| Town of Cuyler | | | Divorce/Legal Separ | |
| Association/Chamber Name (if applicable) | | | Other | |
| | | | Effective Date | COBRA Effective Date |
| Group Administrator Sig | nature/Date | | | |
| X | Hadi 0/2 do | | | |
| | | | Hire/Rehire Date | Retired Effective Date |
| | | | | |
| 2 – Subscriber Pla Selection | Department# | | Employee# | |
| Please use blue o | r black ink, print one ch | aracter per box. C | Check applicable plan(s). | time and namen(a) to be account. |
| ☐ Signature Platinum | | | | e type and person(s) to be covered: |
| Plan (DAA) | | | ☐ Medical ☐ sin | gle 🗆 🕒 family |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 3 - Reason for Eng | <u>rollment/Change</u> e indicate the reason fo | r this annallment o | r change | |
| New Hire | COBRA | Retirement | Loss of Coverage | Domestic Partner |
| Open Enrollment | Address/Phone Number | | Age 65+ Remove De | $\overline{}$ |
| | Please indicate reason for Me | | Newborn Disability | End Stage Renal Disease |
| | | , , <u>, , , , , , , , , , , , , , , , , </u> | | |
| 4 – Subscriber Inf | Please indicate reason for add ormation | ing dependent | Adoption Marriage | Marital Status Change |
| Please complete b | ooth sides of this applic | | | |
| The subscriber sig | gnature is required in o | rder to process the | | |
| Subscriber's Last Name | | | Subscriber's FirstName | |
| Middle Initial Title | E-mail Address | | | |
| Marifica a Address a | | | | |
| Mailing Address | | | Apt or Su | |
| City | | | State Zip | |
| | ايالالالالالا | | | A Marshar |
| Work Phone Number | | me Phone Number | Cell Phor | |
| Date of Birth | - | - | - / | |
| | Gender M F | Social Security Number | | |

| 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 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 LastName Subscriber's FirstName Spouse[/Domestic Partner] Last Name Spouse[/Domestic Partner] FirstName M.I. |
| |
| Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner? |
| Female Yes No |
| Medicare Number (ifapplicable) Part A Effective Date Part B Effective Date |
| |
| Subscriber's Last Name Subscriber's First Name Dependent's Last Name Dependent's First Name N.I. |
| |
| Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes |
| Female |
| 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 |



Town of Cuyler 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 e | ach 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 |
| Female | |
| 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 |
| Female Female | See last page for additional information) 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 |
| Female | |
| Dependent's Last Name | Dependent's First Name M.I. |
| | |
| Mala Data of Disth | Control Constitution and the state of the st |
| Male Date of Birth | Social Security Number Is your over-age dependent handicapped or disabled? Yes |
| Female LLLLLLLLLLLLLLLLLLLLLLLLLLLLLLLLLLLL | |
| 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 |
| Female | [|

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

Transfer to POS

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

- 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 Begin Date COBRA Handicapped/Disabled Date Transfer to Traditional Transfer to HMO

COBRA End Date Subscriber Request Subscriber Deceased Spouse's Insurance Medicaid 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 Dependent Over Age Deceased

COBRA Begin Date Subscriber Request 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 eliqibility

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. 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