

DO NOT USE – FOR INTERNAL PURPOSES ONLY
 HIOS ID# _____
 EC _____

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

Town of Hector
GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY

1 – Group Employer Information

**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 #
 00123215

Subgroup #
 Class#

Employer Name
Town of Hector

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).

Signature Gold (DAG)

Please check coverage type and person(s) to be covered:

Medical single family

3 – Reason for Enrollment/Change

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

New Hire COBRA Retirement Loss of Coverage Domestic Partner
 Open Enrollment Address/Phone Number LastName Age 65+ Remove Dependent Change in Student Status
 Medicare Eligible / Please indicate reason for Medicare eligibility: Newborn Disability End Stage Renal Disease
 Add Dependent/ Please indicate reason for adding dependent: Adoption Marriage 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 LastName
 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 M F Social Security Number - -



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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	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

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