

# WEB ENROLLMENT

FOR EMPLOYERS

Excellus 

Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association

# OVERVIEW

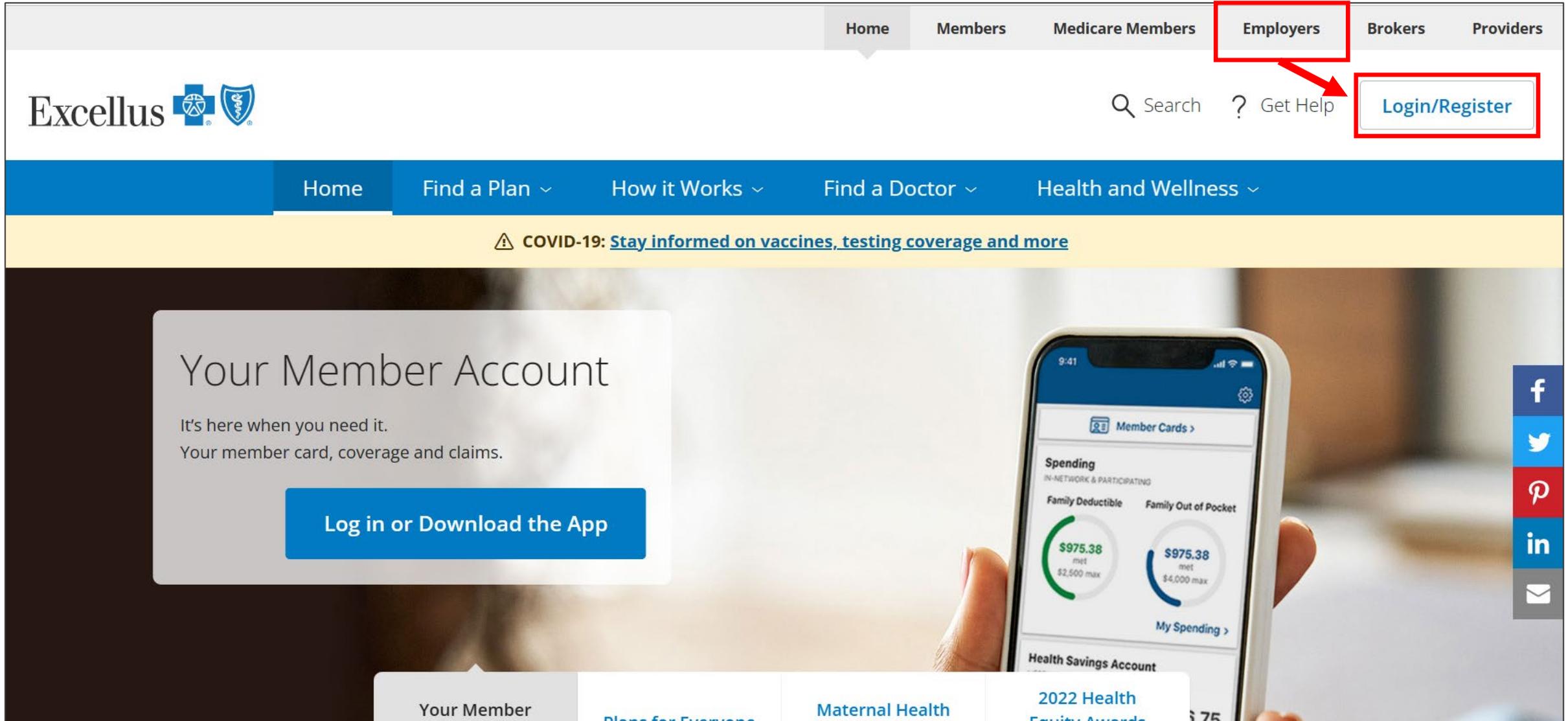
Using this guide as a resource, you will be able to:

3	Log On/Register for an Account
8	Forgot Your Username
11	Forgot Your Password
15	Add/Activate or Remove a Group Number
18	View Member Roster
21	Member Eligibility
23	Add a Family Member
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# LOGGING ON / REGISTERING FOR AN ACCOUNT



1. Navigate to: **ExcellusBCBS.com**
2. Under **EMPLOYERS** tab, Click **LOGIN/REGISTER**



The screenshot shows the website's navigation bar with the following tabs: Home, Members, Medicare Members, Employers, Brokers, and Providers. The 'Employers' tab is highlighted with a red box. Below the navigation bar, there is a search bar and a 'Get Help' link. A red arrow points from the 'Employers' tab to a 'Login/Register' button, which is also highlighted with a red box. Below the navigation bar, there is a blue bar with the following links: Home, Find a Plan, How it Works, Find a Doctor, and Health and Wellness. A yellow banner below the blue bar contains a warning icon and the text: 'COVID-19: Stay informed on vaccines, testing coverage and more'. The main content area features a 'Your Member Account' section with the text: 'It's here when you need it. Your member card, coverage and claims.' and a blue button that says 'Log in or Download the App'. To the right of this section is a smartphone displaying the app's interface, which includes a 'Member Cards' section, a 'Spending' section with two circular progress indicators for 'Family Deductible' and 'Family Out of Pocket' (both at \$975.38 met), and a 'Health Savings Account' section. On the far right, there is a vertical stack of social media icons for Facebook, Twitter, Pinterest, LinkedIn, and Email.

# LOGIN OR REGISTER



Employers

Already a web user?  
**LOG IN HERE**

Login/Register

 We're here for you: Stay informed about the [coronavirus \(COVID -19\)](#)

## Employer Login

**Log In**

[Forgot Your Username?](#)  
[Forgot Your Password?](#)

## Create an Account

- Employee Administration
- Order ID Cards
  - View Member Roster
  - Update Member Policy
- Group Administration
- View or Pay Bills, Setup AutoPay and more
  - Compare New Plan Rates and Benefits
  - Enrollment and Account Maintenance
  - Annual Group Information Form

New to the web?  
**REGISTER & CREATE AN ACCOUNT**

Register & Create an Account

# REGISTER FOR AN ACCOUNT

## Limited Access to Annual Group Information Form (AGIF) Only



Excellus BlueCross BlueShield is required to obtain certain information regarding your group and your employees on an annual basis.

This type of account will allow you to:

- Login with limited access to the AGIF
- Submit this information electronically

You can enter information and sign off on Broker submitted information but will not be able to complete other online transactions.

[Create Your Account](#)

## Online Enrollment and Account Maintenance



These types of accounts will allow you to conduct a wide variety of online transactions.

### Full Access:

- Employee functions: Enroll, Add/Remove Dependents, Update Member Coverage
- Cancel a Policy
- Complete the AGIF Online (Small Groups Only)
- Remove Administrator to allow Broker Access

### Inquiry-Only (View Access):

- Available to Group and Broker
- View Member Roster and Eligibility

[Add/Remove Full Access](#)

[Inquiry-Only \(View Access\)](#)

## Warning

Registering for FULL access will remove your Broker Administrator's ability to conduct transactions on your behalf. Click continue if you wish to proceed.

[Continue](#)

When working with a broker, it is important to know who is going to submit enrollment.  
**Employer or Broker?**

# REGISTER FOR AN ACCOUNT

Online Enroll & Access Request Form for Employer/Group Administrator

*\*Required Field*

Company Information

---

Company Name \*

Federal Tax Identification Number \*

Also known as Employer Identification Number

Group & Sub Group Numbers You will Access \* 

group - 8 digit number or sub group - 12 digit number

Group & Sub Group Numbers You will Access \*  

group - 8 digit number or sub group - 12 digit number

Group & Sub Group Numbers You will Access \*  

group - 8 digit number or sub group - 12 digit number

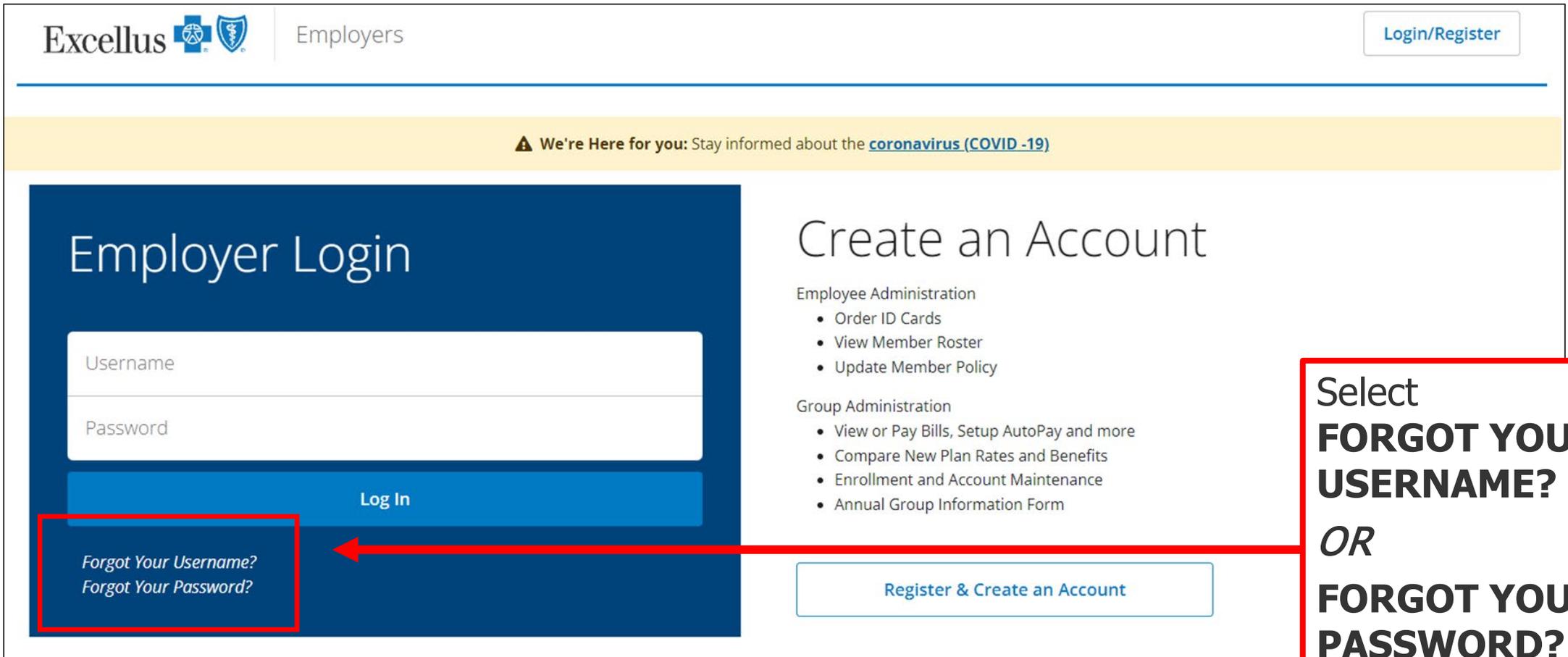
1. Click to add more fields
2. Enter all Group & Sub-Group Numbers
3. Allow 5 business days
4. You will receive an email when the account is active



# FORGOT YOUR USERNAME



# FORGOT YOUR USERNAME OR PASSWORD



The screenshot shows the Excellus Employers portal. At the top left is the Excellus logo and the word 'Employers'. At the top right is a 'Login/Register' button. A yellow banner below the header contains a warning icon and the text: 'We're Here for you: Stay informed about the [coronavirus \(COVID -19\)](#)'. The main content area is split into two columns. The left column is titled 'Employer Login' and contains two input fields for 'Username' and 'Password', a blue 'Log In' button, and a link for 'Forgot Your Username? / Forgot Your Password?' which is highlighted with a red box. A red arrow points from a larger red box on the right towards this link. The right column is titled 'Create an Account' and lists two categories of services: 'Employee Administration' (Order ID Cards, View Member Roster, Update Member Policy) and 'Group Administration' (View or Pay Bills, Setup AutoPay and more, Compare New Plan Rates and Benefits, Enrollment and Account Maintenance, Annual Group Information Form). At the bottom of the right column is a 'Register & Create an Account' button.

Select  
**FORGOT YOUR USERNAME?**  
*OR*  
**FORGOT YOUR PASSWORD?**

# FORGOT YOUR USERNAME

**Call the Web Help Desk**  
1-800-278-1247

## Forgot Username

**▲ We're sorry, we cannot process your request online.**

Please call our Web Security Help Desk for assistance: 1-800-278-1247

# FORGOT YOUR PASSWORD



# FORGOT YOUR PASSWORD

## Forgot Password

**Step 1:** Please complete the following fields

*\* Required Fields*

Username: \*

First Name: \*

Last Name: \*

**1. Enter Username**

**2. Enter First Name and Last Name** on the account

**3. Click CONTINUE**

**Questions?** Contact our Web Help Desk for assistance at 1-800-278-1247.

# FORGOT YOUR PASSWORD

## Forgot Password

**Step 2:** Please provide the correct answer to your secret question

*\* Required Fields*

Your Security Question is: Favorite song?

Security Answer:\*

- 1. Enter the answer to the Security Question**
- 2. Click CONTINUE**



**Questions?** Contact our Web Help Desk for assistance at 1-800-278-1247.

# FORGOT YOUR PASSWORD

Forgot Password

✔ Your Request Was Successful

If the password hint does not help: Call the Web Help Desk for further assistance at **1-800-278-1247**

Step 3: Login to your account.

*\* Required Fields*

Your password hint is:

testing10

If this password hint doesn't help, contact our Web Help Desk for assistance at 1-800-278-1247.

Username: \*

Password: \*

Cancel

Log In

Password Hint will be displayed

1. Enter Username
2. Enter Password
3. Click LOG IN

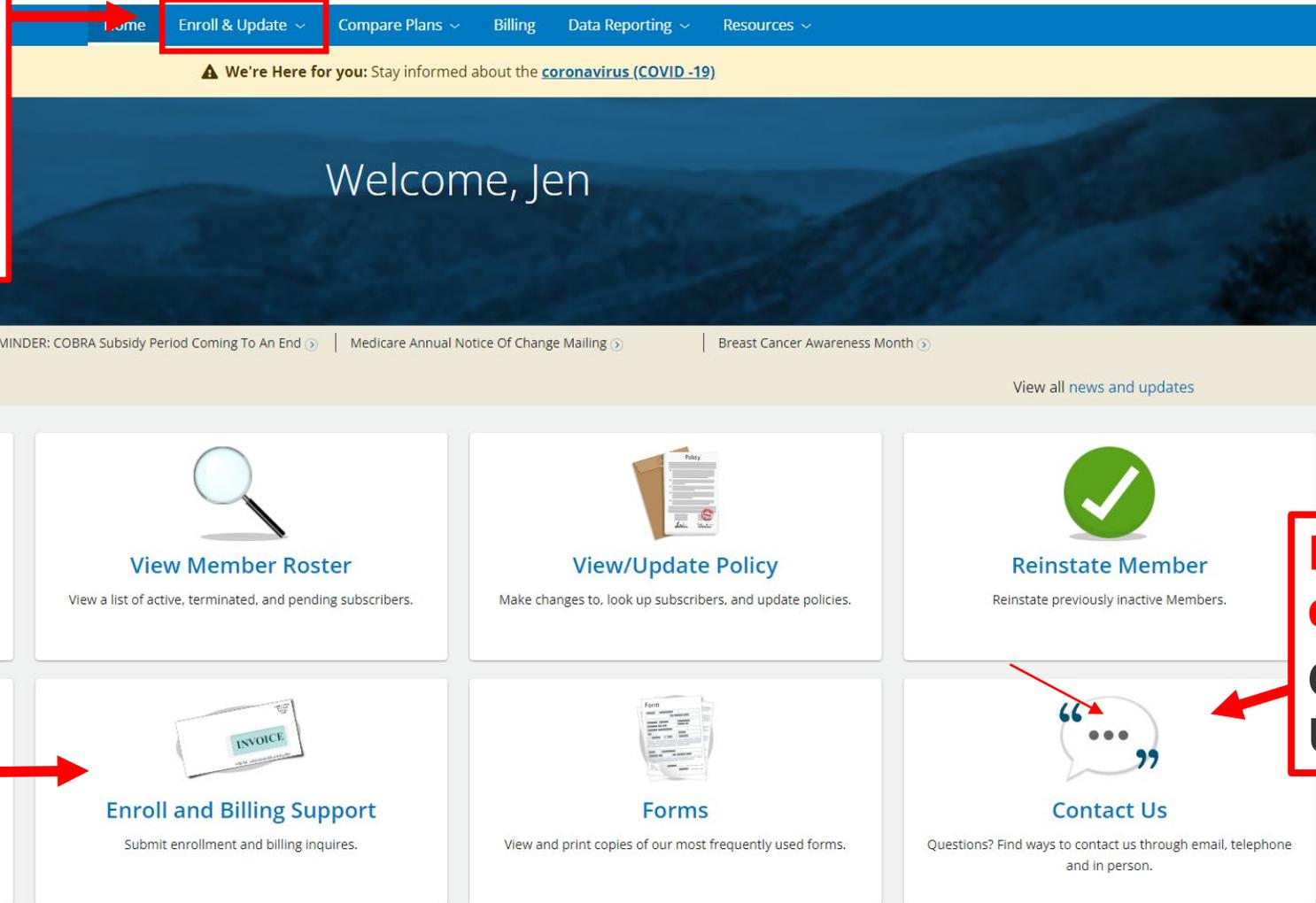
**ADD/ACTIVATE/REMOVE  
GROUP NUMBER**



# CHOOSE YOUR TRANSACTION

## ENROLL & UPDATE MENU:

- Enroll New Members
- View Member Roster
- View/Update Policy
- Reinstate Member

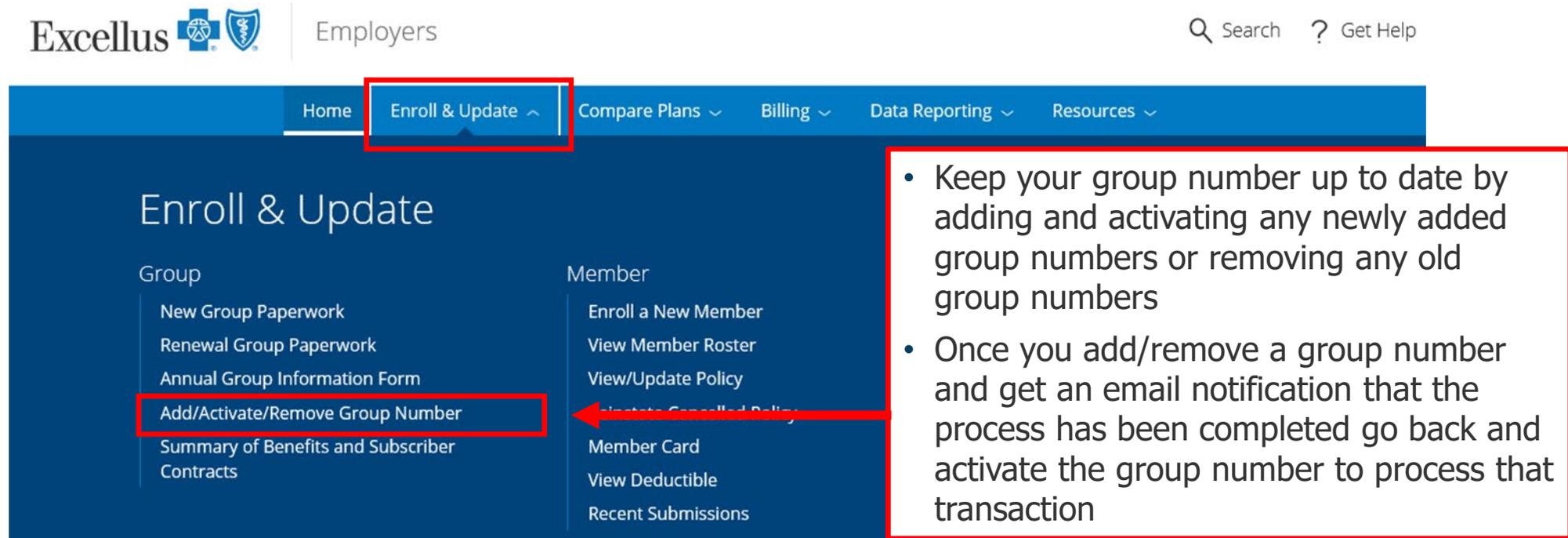


## ENROLL & BILLING SUPPORT MENU:

- Update Member Social Security Number
- Update Member Name
- Reinstate Member
- Contact Enroll & Billing

**Have questions?  
CONTACT US**

# ADD/ACTIVATE, OR REMOVE A GROUP NUMBER



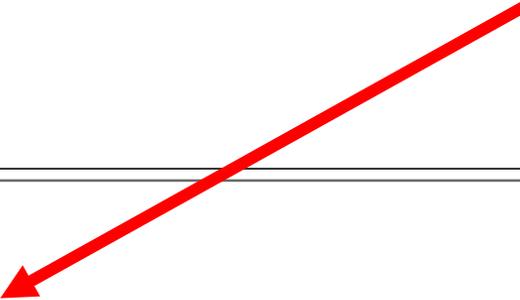
The screenshot shows the Excellus Employers portal. The top navigation bar includes 'Home', 'Enroll & Update', 'Compare Plans', 'Billing', 'Data Reporting', and 'Resources'. The 'Enroll & Update' menu is expanded, showing two columns: 'Group' and 'Member'. The 'Group' column includes 'New Group Paperwork', 'Renewal Group Paperwork', 'Annual Group Information Form', 'Add/Activate/Remove Group Number', and 'Summary of Benefits and Subscriber Contracts'. The 'Member' column includes 'Enroll a New Member', 'View Member Roster', 'View/Update Policy', 'View/Update Policy', 'Member Card', 'View Deductible', and 'Recent Submissions'. A red box highlights the 'Add/Activate/Remove Group Number' option in the 'Group' column. A red arrow points from this option to a callout box on the right. The callout box contains two bullet points: 'Keep your group number up to date by adding and activating any newly added group numbers or removing any old group numbers' and 'Once you add/remove a group number and get an email notification that the process has been completed go back and activate the group number to process that transaction'.

# VIEW MEMBER ROSTER



# VIEW MEMBER ROSTER

Use the check boxes to select group(s)



View Member Roster

Search Group Number

<input type="checkbox"/>	000012340001
<input type="checkbox"/>	000012340002
<input type="checkbox"/>	000012340003
<input type="checkbox"/>	00001234C001
<input type="checkbox"/>	00001234R001

# CHOOSE MEMBER

Filter by  
Employee  
Status

Search by  
name  
*OR*  
Scroll  
through  
the list of  
members

Find A Subscriber

rob

Employee Status

Active

SUBSCRIBER NAME	MEMBER ID	DATE OF BIRTH	GENDER	PACKAGE ID	CONTACT TYPE	STATUS	DEPT CODE	EMP NUM	PAY LOCATION
Robert			Male	MSMC0101	Subscriber	Active			
Robert			Male	MSMH0197	Subscriber	Active			
Robin			Female	MSMC0101	Subscriber	Active			

Show 10 entries

Showing 1-3 of 3 Results (filtered from 5 total entries)

As a user starts to type a name into the search bar, the search results will filter using predictive text.

# MEMBER ELIGIBILITY



# CHOOSE THE ENROLLMENT TRANSACTION

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

**SUBSCRIBER INFORMATION** Subscriber Name

Address Subscriber Address  
Phone Subscriber Phone  
Date Of Birth Subscriber Date of Birth  
Gender Subscriber Gender  
Member ID Member ID

**POLICY INFORMATION**

Plan Name SimplyBlue Plus PPO Copay  
Status ✔ ACTIVE  
Effective Date/ Term Date 01/01/2021 -  
Group Name Group Name  
Group Number Group Number  
Employee Number  
Contract Type Subscriber and Spouse  
Class Id A001  
Dependent Covered To 26 YEARS  
Student Covered To 26 YEARS

**TERMED POLICIES**

**FAMILY MEMBER INFORMATION** Family Member Details

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP
Name	00	Active	DOB	36	Subscriber	Male		
Name	01	Active	DOB	29	Wife	Female		

**Update Subscriber Information**

**Update Policy Information**

**Add or Remove a Family Member**

# ADD A FAMILY MEMBER



# ADD A FAMILY MEMBER

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

**SUBSCRIBER INFORMATION** Subscriber Name

Address Subscriber Address [Change Address/Phone Number](#)

Phone Subscriber Phone

Date Of Birth Subscriber Date of Birth [Request Member Card](#)

Gender Subscriber Gender

Member ID Member ID

**POLICY INFORMATION**

Plan Name SimplyBlue Plus PPO Copay [Change Coverage](#)

Status ✔ ACTIVE [Cancel Coverage](#)

Effective Date/ Term Date 01/01/2021 -

Group Name Group Name [Ask a Membership Question](#)

Group Number Group Number

Employee Number

Contract Type Subscriber and Spouse

Class Id A001

Dependent Covered To 26 YEARS

Student Covered To 26 YEARS

**TERMED POLICIES**

**FAMILY MEMBER INFORMATION**

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP	
Name	00	Active	DOB	36	Subscriber	Male			<a href="#">Add a Family Member</a>
Name	01	Active	DOB	29	Wife	Female			<a href="#">Remove a Family Member</a>

- Name Change
- Update SSN
- Questions

**Add a Family Member**

# ADD A FAMILY MEMBER

Add a Dependent *\* Anything starred in RED is required*

**\* Required Fields**

[Follow this link to Reinstate a Canceled Policy within 30 days of termination](#)

Subscriber Name:	Subscriber Name	Subscriber ID:	Subscriber ID
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**Group & Subscriber Information**

Group/Employer Information

Qualifying Event Date: \*

Desired Effective Date: \*

Employee Status: \*

Employee Number:

Department Number:

[Continue ▶](#)

When adding a Family Member use **Qualifying Event Date**

- Date of Birth
- Date of Marriage
- Date of Adoption
- Paperwork is not required for web enrollment – Excellus will send out for QMCS (Qualified Medical Child Support) order, Adoption and Handicap

Group/Employer Information

Qualifying Event Date: \*  **Please Select**

Desired Effective Date: \*  **Event Date must be prior to Effective Date**

Employee Status: \*

Employee Number:

Department Number:

[Continue ▶](#) **Please fix the errors above before continuing.**

Desired Effective Date CANNOT be before **Qualifying Event Date**

# ADD A FAMILY MEMBER

Subscriber Name:	Subscriber Name	Subscriber ID:	Subscriber ID
<b>Group &amp; Subscriber Information</b>			
<b>Family Member Information</b>			
To add a new dependent, click the 'Add a Family Member' button below.			
<div style="border: 2px solid red; padding: 5px; display: inline-block;"><b>Add a Family Member</b></div>			
- or -			
Select an existing family member we may have on record from the selection below:			
<input type="text" value="- Select -"/>		<b>Add an Existing Dependent</b>	
<b>◀ Back</b>		<b>Continue ▶</b>	
<b>Legal Statements</b>			

# ENTER FAMILY MEMBER INFORMATION

Family Member Information

Family Member

Relationship to Subscriber: \* - Select -

First Name: \*

Last Name: \*

Title: - Select -

Gender: \*  Male  Female  Gender X

Date of Birth: \*  MM-DD-YYYY

Social Security Number:

We are required to ask for the Social Security number for members greater than one year old in order to meet our reporting obligations under the Affordable Care Act.

Select Coverage:  SimplyBlue Plus PPO Copay 15/25/150

- When adding a **Dependent Student** student age should be **19-26**
- When selecting a **Handicapped Dependent** the dependent should be **over 26** years old

Make sure to select coverage or dependent will not be added

# MAKE CHANGES OR CONTINUE

Subscriber Name:  Subscriber ID:

## Group & Subscriber Information

## Family Member Information

Name	Relationship	Date of Birth	Select Coverage	
Dependent Name	Dependent (Child, Stepchild)	DOB	<input checked="" type="checkbox"/> SimplyBlue Plus PPO Copay 15/25/150	<a href="#">Edit</a> <a href="#">Delete</a>

To add a new dependent, click the 'Add a Family Member' button below.

- or -

Select an existing family member we may have on record from the selection below:

**Add an Additional Family Member**

*OR*

**Continue**

# MEDICARE INFORMATION

Subscriber Name: Subscriber Name

**Group & Subscriber Information**

**Family Member Information**

**Medicare Information**

Medicare Eligibility

Do any of the new dependents have Medicare coverage? \*  Yes  No

**Other Coverage Information**

**Legal Statements**

**Medicare Information**

Medicare Eligibility

Do any of the new dependents have Medicare coverage? \*  Yes  No

Which members currently have Medicare coverage? \*  John Smith(08-10-2021)

John's Medicare Coverage Information

Reason for Medicare Eligibility: \*

Health Insurance Claim Number: \*

Effective Date - Medicare A: *Dependent Name (mm/dd/yyyy)*

Effective Date - Medicare B:  

You are required to fill in at least one of the above Effective Dates.

**Select YES or NO**  
 If **YES** is selected,  
**Medicare Information** window opens

# OTHER COVERAGE

Subscriber Name: Subscriber Name

Group & Subscriber Information

Family Member Information

Medicare Information

Other Coverage Information

Other Coverage

Have any of the new dependents had coverage under another health or dental insurance carrier during the last 63 days? \*

Yes  No

Other Coverage Information

Other Coverage

Have any of the new dependents had coverage under another health or dental insurance carrier during the last 63 days? \*  Yes  No

Which members have or had other coverage? \*  Dependent Name (mm/dd/yyyy)

John's Other Insurance Information

Other Carrier Name: \*

Are you keeping this other insurance? \*  Yes  No

If no, what is the cancellation date? \* MM-DD-YYYY

Effective Date of Other Insurance: \* MM-DD-YYYY

Policy Holder's First Name: \*

Policy Holder's Last Name: \*

Policy Holder's Insurance Number: \*

Type of Coverage: \* - Select -

Persons Covered: \* - Select -

Relationship to Subscriber: \* - Select -

**Select YES or NO**

If **Yes** is selected,  
**Other Coverage Information window** opens

- Coverage Information is required when coordinating benefits with another Medical or Dental Insurance carrier
- Use Other when not listed

# LEGAL STATEMENTS

## Legal Statements

Please check the statements below on behalf of the subscriber, and keep a copy of the signed application for your records.

### Subscriber Acceptance

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.

I Agree \*

### Medical Release Acceptance

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 whom we contract, including pharmacy benefit managers, disease management vendors or surveyors. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree \*

[← Back](#)

# ADD A FAMILY MEMBER SUMMARY

<p>Subscriber Name: Subscriber Name</p> <p><b>Group/Employer Information</b></p> <p>Employee Number:</p> <p>Employee Status: <b>Active</b></p> <p>Desired Effective Date: <b>09-01-2021</b></p> <p><b>Subscriber Information</b></p> <p>First Name: Subscriber First Name</p> <p>Last Name: Subscriber Last Name</p> <p>Gender: Subscriber Gender</p> <p><b>Address Information</b></p> <p>Street Address: Subscriber Address</p> <p>City:</p> <p>State/Province:</p> <p>Zip/Postal Code:</p>	<p><b>Family Member Information</b></p> <p><b>Dependent</b> <span style="float: right;">* Delete Edit</span></p> <p>First Name: Dependent First Name</p> <p>Last Name: Dependent Last Name</p> <p>Relationship to Subscriber: <b>Dependent (Child, Stepchild)</b></p> <p>Gender: <b>Male</b> Social Security Number:</p> <p>Date of Birth: <b>DOB</b></p> <p><a href="#">Add a Family Member</a></p> <p><b>Persons Covered:</b> SimplyBlue Plus PPO Copay 15/25/150</p> <p>Subscriber First Name <input checked="" type="checkbox"/></p> <p><b>Medicare Information</b></p> <p>Do you or your family members have Medicare coverage? <b>No</b></p> <p><b>Other Coverage Information</b></p> <p>Have you or any of your family members had <b>No</b> coverage under another health or dental insurance carrier during the last 63 days?</p> <p style="text-align: center;">If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above.</p> <p style="text-align: right;"><a href="#">Submit</a></p>
---	--

Edit or Delete Dependent Information

Add an additional Family Member

Make sure that the dependents that were included have the green check mark

# ADD A DEPENDENT CONFIRMATION

1. Print Enrollment Form
2. Save as PDF or use Recent Submissions
3. Allow 3-5 business days

## Add a Dependent Confirmation

### Submission Receipt

 Thank You! Your application for **Subscriber Name** was received.

Depending on any additional enrollment requirements, your transaction will be processed within 3 to 5 business days.

Your confirmation number is: 2021-08-18 15:56:23.83784

Subscriber ID(s): Subscriber ID

 **Please print or save this receipt and keep a copy of the signed application for your records.**

 [Print Enrollment Form](#)

 [Save Enrollment Form as PDF](#)

# REMOVE A FAMILY MEMBER



# REMOVE A FAMILY MEMBER

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

**SUBSCRIBER INFORMATION:** Subscriber Name

Address: Subscriber Address [Change Address/Phone Number](#)

Phone: Subscriber Phone

Date Of Birth: Subscriber Date of Birth [Request Member Card](#)

Gender: Subscriber Gender

Member ID: Member ID

**POLICY INFORMATION**

Plan Name: SimplyBlue Plus PPO Copay [Change Coverage](#)

Status: ✔ ACTIVE [Cancel Coverage](#)

Effective Date/ Term Date: 01/01/2021 -

Group Name: Group Name [Ask a Membership Question](#)

Group Number: Group Number

Employee Number:

Contract Type: Subscriber and Spouse

Class Id: A001

Dependent Covered To: 26 YEARS

Student Covered To: 26 YEARS

**TERMED POLICIES**

**FAMILY MEMBER INFORMATION**

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP	
Name	00	Active	DOB	36	Subscriber	Male			<a href="#">Add a Family Member</a>
Name	01	Active	DOB	29	Wife	Female			<a href="#">Remove a Family Member</a>

Select  
**REMOVE A FAMILY MEMBER**



# REMOVE A FAMILY MEMBER

## Remove a Family Member

Please complete the following information and click submit.

Only active groups for which there is currently dependent coverage are available for selection.

### Select the current Group

### Employer Identification Number (EIN):

XX-XXXXXXXX

### Desired Cancellation Date

 (mm/dd/yyyy)

Use **ADD** or **REMOVE** Group Numbers form to Add and Activate

# DEPENDENT CANCEL

## Dependent Cancel

Please review the following information, make changes and click submit.

Group Name

Group Name

Group Number

Group Number

Insurance Product

SimplyBlue Plus PPO Copay 15/25/150

Current Persons Covered

Subscriber and Spouse

New Persons Covered

Reason for Cancellation

Submit

**Important:** Use the accurate Reason for Cancellation and Date

- Date of Divorce
- Date of Court Order, etc.

**1. Select New Type of Coverage** (Self, Family, Family/no spouse, Insured & Spouse)

**2. Select reason for cancellation**

**3. Submit**

# DEPENDENT CANCEL

**View/Update Policy**

Please complete the following information and click submit.

Select which policies you would like to cancel:

Dependent Name	DOB

Current Medical Coverage

Cancel

Please read and accept the following statements:

**Subscriber Acceptance**

Any person who knowingly and with intent to defraud any insurance company or other person files a false claim, or conceals for the purpose of misleading, information concerning any fact material to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have

I agree

**Medical Release Acceptance**

I authorize Excellus BlueCross BlueShield to request and receive medical essential information regarding my care from any health care provider, hospital, or other institution either orally or in writing and to use this information for providing coverage. Providing coverage; and quality assurance reviews of care, whether based on a specific complaint or a routine audit of care; and to disclose this information to third parties with whom we contract, including pharmacy benefit managers, and to use this information for providing coverage. I agree to comply with the terms of the Release.

I agree

**1. All Dependents will be listed, check the box ONLY for dependents you are REMOVING**

**2. Agree to Subscriber Acceptance**

**3. Agree to Medical Release Acceptance**

**4. Select Submit**

# DEPENDENT CANCEL CONFIRMATION

## Dependent Cancel Confirmation

Dependent Name      DOB

**Desired  
Cancellation Date**      9/1/2021

**Policies to be  
Cancelled**      SimplyBlue Plus PPO Copay 15/25/150

**Reason for  
Cancellation**      Dependent No Longer Wants Coverage

Is the above information correct?

Yes

No

Cancel



# CHANGE COVERAGE



# CHANGE COVERAGE

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

**SUBSCRIBER INFORMATION:** Subscriber Name

Address: Subscriber Address [Change Address/Phone Number](#)

Phone: Subscriber Phone

Date Of Birth: Subscriber Date of Birth [Request Member Card](#)

Gender: Subscriber Gender

Member ID: Member ID

**POLICY INFORMATION**

Plan Name: SimplyBlue Plus PPO Copay [Change Coverage](#)

Status: ✔ ACTIVE [Cancel Coverage](#)

Effective Date/ Term Date: 01/01/2021 - [Ask a Membership Question](#)

Group Name: Group Name

Group Number: Group Number

Employee Number:

Contract Type: Subscriber and Spouse

Class Id: A001

Dependent Covered To: 26 YEARS

Student Covered To: 26 YEARS

**TERMED POLICIES** ▼

**FAMILY MEMBER INFORMATION**

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP	
Name	00	Active	DOB	36	Subscriber	Male			<a href="#">Add a Family Member</a>
Name	01	Active	DOB	29	Wife	Female			<a href="#">Remove a Family Member</a>

Select **Change Coverage**

- Use **Medical Change Coverage** to change Medical AND Dental
- Need to submit **2 separate change coverage enrollments for medical and dental with different effective dates**

# CHANGE COVERAGE

Subscriber Name:	Subscriber ID:
------------------	----------------

### Group & Subscriber Information

**Group/Employer Information**

**Desired Effective Date:** \*

**Employee Status:** \*

**Employee Number:**

**Department Number:**

**Subscriber Information**

**First Name:** \*

**Last Name:** \*

**Title:**

**Gender:**

**Date of Birth:** \*

**Subscriber ID:**

**Address Information**

**Is the address in 'Care Of?'**

**Street Address:** \*

**City:** \*

**Country:** \*

**State/Province:** \*

**Zip/Postal Code:** \*

**Daytime Phone Number:**

**Email Address:**

# SELECT COVERAGE

### Select Coverage

Select Medical Plan

Current Medical Policy for Subs ID: 000001173			
Medical Group Number:	Class:	Enrollment Code:	Package-Product Name:
XXXXXXXX0001	All Actives	XXXX	SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500

Would you like to change/add your Medical coverage?  Yes

To change or add new Medical coverage to this policy, click the checkbox and select a new plan from the options below.

Select Drug plan

Would you like to change/add your RxOnly coverage?  Yes

Select Dental Plan

Would you like to change/add your Dental coverage?  Yes

Select Vision plan

Would you like to change/add your Vision coverage?  Yes

[Back](#) [Continue](#)

**Dental/Rx/  
Vision will  
only display  
if applicable**

**• Select YES to CHANGE/ADD any of the available coverages**  
*(Leaving the box unchecked indicates that you do not want to change/add that specific coverage)*

# FAMILY MEMBER INFORMATION

Subscriber Name:	Subscriber Name	Subscriber ID:	Subscriber ID
------------------	-----------------	----------------	---------------

**Group & Subscriber Information**

**Select Coverage**

**Family Member Information**

To enroll members, check the policy(ies) for each family member. Use 'Edit' links to update dependent profile information.

Name	Relationship	Date of Birth	Select Coverage	
Spouse Name	Spouse	DOB	<input checked="" type="checkbox"/> SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500	<a href="#">Edit</a>
Dependent Name	Dependent (Child, Stepchild)	DOB	<input type="checkbox"/> SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500	<a href="#">Edit</a>

[Add a Family Member](#)

[← Back](#) [Continue ▶](#)

**Medicare Information**

**Other Coverage Information**

**Legal Statements**

**Must select coverage for all dependents**  
*If coverage is not selected, dependents will lose coverage with the change*

# MEDICARE, OTHER COVERAGE INFORMATION, LEGAL STATEMENTS

### Medicare Information

Medicare Eligibility

Do you or your family members have Medicare coverage? \*  Yes  No

### Other Coverage Information

Other Coverage

Have you or any of your family members had coverage under another health or dental insurance carrier during the last 63 days? \*  Yes  No

### Legal Statements

Please check the statements below on behalf of the subscriber, and keep a copy of the signed application for your records.

**Subscriber Acceptance**

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.

I Agree \*

**Medical Release Acceptance**

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 whom we contract, including pharmacy benefit managers, disease management vendors or surveyors. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree \*

# CHANGE COVERAGE SUMMARY

Subscriber Name:	Subscriber Name	Subscriber ID:	Subscriber ID
------------------	-----------------	----------------	---------------

**Group/Employer Information** [Edit](#)

Employee Number:		Department Number:	
Employee Status:	Active	Desired Effective Date:	

**Subscriber Information**

First Name:	First Name	Title:	
Last Name:	Last Name		
Gender:	Gender	Subscriber ID:	
Date of Birth:	DOB		

**Address Information**

Street Address:	Address	Daytime Phone Number:	
City:	City	Email Address:	
State/Province:	State		
Zip/Postal Code:	Zip Code	Country:	

**Select Coverage**

Medical Group Number:	XXXXXXXX-0001	Medical Class:	
Medical Enrollment Code:	XXXX		

**Family Member Information**

**Spouse** [Edit](#)

First Name:	First Name	Title:	
Last Name:	Last Name		
Relationship to Subscriber:	Spouse		
Gender:	Gender	Social Security Number:	SSN
Subscriber ID:	Subscriber ID	Date of Birth:	DOB

**Dependent** [Edit](#)

First Name:	First Name	Title:	
Last Name:	Last Name		
Relationship to Subscriber:	Dependent		
Gender:	Gender	Social Security Number:	SSN
Subscriber ID:	Subscriber ID	Date of Birth:	DOB

[Add a Family Member](#)

# CHANGE COVERAGE SUMMARY (CONT.)

Persons Covered: SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500	
Subscriber Name	✓
Dependent Name	✓
Dependent Name	✓

Green check marks indicate dependents were included

## Medicare Information [Edit](#)

Do you or your family members have Medicare coverage? **No**

## Other Coverage Information [Edit](#)

Have you or any of your family members had coverage under another health or dental insurance carrier during the last 63 days? **No**

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above. [Submit](#)

# CHANGE COVERAGE CONFIRMATION

## Change Coverage Confirmation

### Submission Receipt

 Thank You! Your application for **Subscriber Name** was received.

Depending on any additional enrollment requirements, your transaction will be processed within 3 to 5 business days.

**Your confirmation number is: 2021-10-29 13:57:42.949302**

**Subscriber ID(s):** Subscriber ID

 **Please print or save this receipt and keep a copy of the signed application for your records.**

 [Print Enrollment Form](#)

 [Save Enrollment Form as PDF](#)

# CANCEL COVERAGE



# CANCEL COVERAGE

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

Subscriber Name

**SUBSCRIBER INFORMATION:**

Address  Subscriber Address [Change Address/Phone Number](#)

Phone  Subscriber Phone [Request Member Card](#)

Date Of Birth  Subscriber Date of Birth

Gender  Subscriber Gender

Member ID  Member ID

**POLICY INFORMATION**

Plan Name  SimplyBlue Plus PPO Copay [Change Coverage](#)

Status  ✔ ACTIVE [Cancel Coverage](#)

Effective Date/ Term Date  01/01/2021 - [Ask a Membership Question](#)

Group Name  Group Name

Group Number  Group Number

Employee Number

Contract Type  Subscriber and Spouse

Class Id  A001

Dependent Covered To  26 YEARS

Student Covered To  26 YEARS

**TERMED POLICIES** ▼

**FAMILY MEMBER INFORMATION**

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP	
Name	00	Active	DOB	36	Subscriber	Male			<a href="#">Add a Family Member</a>
Name	01	Active	DOB	29	Wife	Female			<a href="#">Remove a Family Member</a>

Select  
**CANCEL COVERAGE**

# SELECT POLICY(IES) TO CANCEL

## Cancel Coverage

 Only active policies are displayed below. By canceling a policy, you are also canceling coverage for all family members on the policy.

Subscriber:

Subscriber Name

ID:

Subscriber ID

### Coverage Information

Select Policy(ies) to Cancel: \*

SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500

Continue

# REASON FOR CANCELLATION & DESIRED CANCELLATION DATE

## Cancel Coverage

Only active policies are displayed below. By canceling a policy, you are also canceling coverage for all family members on the policy.

Subscriber:	Subscriber Name	ID:	Subscriber ID

**Coverage Information**

Select Policy(ies) to Cancel: \*  SimplyBlue Plus PPO Hybrid 40

Reason for Cancellation: \* - Select -

Desired Cancellation Date: \* MM-DD-YYYY

Continue

Select Cancellation Reason from Drop Down

- Select -  
 Left Employment  
 Employee No Longer Wants Coverage  
 Deceased  
 Subgroup Transfer  
 Change in Employee Eligibility Status  
 Medicare Eligible  
 Enrolled in Error  
 Layoff Without Benefits

Desired Cancellation Date must be **on or before the last day of the month**

# CANCEL COVERAGE SUMMARY

## Cancel Coverage Summary

**i** Please use the 'Edit' buttons below to make any corrections. Then click 'Submit' to finalize cancellation.

Subscriber:	Subscriber Name	ID:	Subscriber ID
<div style="display: flex; justify-content: space-between; align-items: center;"> <span><b>Coverage Information:</b></span> <span style="color: blue; font-size: small;">✎ Edit</span> </div>			
Policy(ies) to be Cancelled:	SimplyBlue Plus PPO Hybrid 40/60/350 2250/4500		
Reason for Cancellation:	Employee No Longer Wants Coverage		
Desired Cancellation Date:	10-31-2021		

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above.

**1. Verify information is correct**

**2. Click SUBMIT**

**Submit**

# CANCEL COVERAGE CONFIRMATION

## Cancel Coverage Confirmation

### Submission Receipt

Thank You! Your request to cancel coverage for **Subscriber Name** was received.

Depending on any additional requirements, your transaction will be processed within 3 to 5 business days.

**Your confirmation number is: 2021-10-29 14:27:49.128902**

**Subscriber ID(s):** Subscriber ID

**⚠ Please print or save this receipt for your records.**

 [Print Cancel Coverage Form](#)

 [Save Cancel Coverage Form as PDF](#)

# REINSTATE POLICY



# REINSTATE POLICY

- In order to reinstate a policy, it must be in **Cancelled Status**
- You can go back to the 1<sup>st</sup> of the previous month
- You will receive an edit message if you try to go back further and the reinstate Termination Policy button will no longer display

## Reinstate Cancelled Policy

Follow the steps below to request that a subscriber's cancelled or terminated policy be made active again.

**Step 1:** Lookup the subscriber's cancelled policy using [View/Update Policy](#).

**Step 2:** On the View/Update Policy page, under the Policy Information section, select the Reinstate Terminated Policy button.

**NOTE:** A policy can only be reinstated within 30 days of termination, so if there is no Reinstate Terminated Policy button, you will need to re-enroll the member in a new policy.

Example - Policy information with Reinstate Terminated Policy button

### POLICY INFORMATION

#### TERMED POLICIES

Plan Name	Example Plan
Status	<span>✖</span> <b>TERMED</b>
Effective Date/ Term Date	01/01/2019 - 02/08/2020
Group Name	Example Group
Group Number	00#####-0001
Employee Number	#####

Change Coverage

Cancel Coverage

Reinstate Terminated Policy

Ask a Membership Question or Enrollment & Billing support form can be used when going beyond that time frame for reinstate

Change Coverage

Cancel Coverage

Reinstate Terminated Policy

Ask a Membership Question

# CHANGE ADDRESS/ PHONE NUMBER



# CHANGE ADDRESS/PHONE NUMBER

View/Update Policy

[Return to Roster](#) [Print](#) [Download as PDF](#)

SUBSCRIBER INFORMATION: Subscriber Name

Address	Subscriber Address	<a href="#">Change Address/Phone Number</a>
Phone	Subscriber Phone	<a href="#">Request Member Card</a>
Date Of Birth	Subscriber Date of Birth	
Gender	Subscriber Gender	
Member ID	Member ID	

POLICY INFORMATION

Plan Name	SimplyBlue Plus PPO Copay	<a href="#">Change Coverage</a>
Status	<span style="color: green;">✔</span> ACTIVE	<a href="#">Cancel Coverage</a>
Effective Date/ Term Date	01/01/2021 -	<a href="#">Ask a Membership Question</a>
Group Name	Group Name	
Group Number	Group Number	
Employee Number		
Contract Type	Subscriber and Spouse	
Class Id	A001	
Dependent Covered To	26 YEARS	
Student Covered To	26 YEARS	

TERMED POLICIES

FAMILY MEMBER INFORMATION

MEMBER NAME	MEMBER SUFFIX	STATUS	BIRTH DATE	AGE	RELATIONSHIP	GENDER	CURRENT PCP	ALT PCP	
Name	00	Active	DOB	36	Subscriber	Male			<a href="#">Add a Family Member</a>
Name	01	Active	DOB	29	Wife	Female			<a href="#">Remove a Family Member</a>

Select  
**Change  
Address/Phone  
Number**

# CHANGE YOUR ADDRESS AND PHONE NUMBER

## Change Address and Phone

Subscriber Subscriber Name

---

**CURRENT INFORMATION**

---

<b>Street Address</b>	123 Street Name City, State, Zip Code		<b>Edit</b>
<b>Phone Number</b>	(xxx) xxx - <u>xxxx</u>		<b>Edit</b>

**1. EDIT Address**  
*AND/OR*  
**EDIT Phone Number**

**2. Select UPDATE**

**Update**

**Cancel**

# CHANGE ADDRESS AND PHONE NUMBER FORMS

Subscriber   Subscriber Name

---

**CURRENT INFORMATION**

---

Is this address within the United States?

Yes  
 No

Will the new address be in care of?

Yes  
 No

Street Address

City

State

Zipcode

---

Phone Number

**Change Address**

**Change Phone Number**

# CHANGE ADDRESS AND PHONE CONFIRMATION

## Change Address and Phone

✔ Your information is successfully updated!

Subscriber Subscriber Name

### CURRENT INFORMATION

<b>Street Address</b>	123 Street Name City, State, Zip Code	<a href="#">Edit</a>
<b>Phone Number</b>	(xxx) xxx - <u>xxxx</u>	<a href="#">Edit</a>

[Return to Eligibility](#)

# ENROLL A NEW MEMBER



# ENROLL A NEW MEMBER

Excellus Employers Search Get Help

Home **Enroll & Update** Compare Plans Billing Data Reporting Resources

## Enroll & Update

- Group
  - New Group Paperwork
  - Renewal Group Paperwork
  - Annual Group Information Form
  - Add/Activate/Remove Group Number
  - Summary of Benefits and Subscriber Contracts
- Member
  - Enroll a New Member**
  - View Member Roster
  - View/Update Policy
  - Reinstate Cancelled Policy
  - Member Card
  - View Deductible
  - Recent Submissions

**1. ENROLL & UPDATE**  
**2. ENROLL A NEW MEMBER**

**Enroll New Member**  
Enroll new members.

**View Member Roster**  
View a list of active, terminated, and pending subscribers.

**View/Update Policy**  
Make changes to, look up subscribers, and update policies.

**Reinstate Member**  
Reinstate previously inactive Members.

**Member Card**  
Order new Member Cards or print Temporary Proof of Coverage.

**Enroll and Billing Support**  
Submit enrollment and billing inquiries.

**Forms**  
View and print copies of our most frequently used forms.

**Contact Us**  
Questions? Find ways to contact us through email, telephone and in person.

**Group & Subscriber Information**

**Group/Employer Information**

Reason for Enrollment: \*

Desired Effective Date: \*  

Employee Status: \*

Employee Number:

Department Number:

**Subscriber Information**

First Name: \*

Last Name: \*

Title:

Gender: \*  Male  Female  Gender X

Date of Birth: \*  

Social Security Number: \*

We are required to ask for the Social Security number for members greater than one y

**Address Information**

Is the address in 'Care Of?'

Street Address: \*

City: \*

Country: \*

State/Province: \*

Zip/Postal Code: \*

Daytime Phone Number:

Email Address:

[Continue >](#)

[Select Coverage](#)

[Family Member Information](#)

[Medicare Information](#)

[Other Coverage Information](#)

[Legal Statements](#)

- You can submit 1 enrollment transaction for Medical & Dental (as well as Vision & Rx, if applicable)
- Submit separate transactions for policies with different start dates

# SELECT COVERAGE

Group & Subscriber Information

Select Coverage

Select Medical Plan

Decline or Keep Existing Plan:

Medical Group Number: \* - Select -

Select Drug plan

Decline or Keep Existing Plan:

RxOnly Group Number: \* - Select -

Select Dental Plan

Decline or Keep Existing Plan:

Dental Group Number: \* - Select -

Select Vision plan

Decline or Keep Existing Plan:

Vision Group Number: \* - Select -

◀ Back
Continue ▶

- **Select DECLINE if the subscriber DOESN'T want coverage**
- You must **select at least 1 coverage**
- **Select Group number, Class, & Enrollment Code**
- Continue for Dental, Rx, and Vision if applicable

If one (or more) of these plan options are not showing, it means that the groups you have access to do not offer these types of plans

# ADD A FAMILY MEMBER

Group & Subscriber Information

Select Coverage

Family Member Information

To enroll family members, click the 'Add a Family Member' button below. Otherwise click 'Continue'.

Add a Family Member

◀ Back

Continue ▶

Medicare Information

Other Coverage Information

Legal Statements

**Helpful Resources**

[Employer News & Updates](#)

[Forms](#)

Family Member Information

Family Member

**Relationship to Subscriber:** \* - Select -

**First Name:** \*

**Last Name:** \*

**Title:** - Select -

**Gender:** \*  Male  Female  Gender X

**Date of Birth:** \*  MM-DD-YYYY

**Social Security Number:**

We are required to ask for the Social Security number for members greater than one year old in order to meet our reporting obligations under the Affordable Care Act.

**Select Coverage:**  Excellus Plan Name

Save

Cancel

- Select -
- Spouse
- Domestic Partner
- Dependent (Child, Stepchild)
- Dependent Student (19 or older)
- Handicapped Dependent

**Select SAVE**  
**Repeat process for any additional family members**

67

# MEDICARE, OTHER COVERAGE INFORMATION, LEGAL STATEMENTS

### Medicare Information

Medicare Eligibility

Do you or your family members have Medicare coverage? \*  Yes  No

### Other Coverage Information

Other Coverage

Have you or any of your family members had coverage under another health or dental insurance carrier during the last 63 days? \*  Yes  No

### Legal Statements

Please check the statements below on behalf of the subscriber, and keep a copy for the record.

**Subscriber Acceptance**

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.

I Agree

**Medical Release Acceptance**

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 whom we contract, including pharmacy benefit managers, disease management vendors or surveyors. I have thoroughly read, understand and agree to comply with the terms of the Release.

I Agree

# CHANGE COVERAGE SUMMARY



Subscriber Name:	Subscriber Name	Subscriber ID:	Subscriber ID
------------------	-----------------	----------------	---------------

## Group/Employer Information [Edit](#)

Employee Number:		Department Number:	
Employee Status:	Active	Desired Effective Date:	

## Subscriber Information

First Name:	First Name	Title:	
Last Name:	Last Name		
Gender:	Gender	Subscriber ID:	
Date of Birth:	DOB		

## Address Information

Street Address:	Address	Daytime Phone Number:	
City:	City	Email Address:	
State/Province:	State		
Zip/Postal Code:	Zip Code	Country:	

## Select Coverage

Medical Group Number:	XXXXXXXX-0001	Medical Class:	
Medical Enrollment Code:	XXXX		

## Family Member Information

### Spouse [Edit](#)

First Name:	First Name	Title:	
Last Name:	Last Name		
Relationship to Subscriber:	Spouse		
Gender:	Gender	Social Security Number:	SSN
Subscriber ID:	Subscriber ID	Date of Birth:	DOB

### Dependent [Edit](#)

First Name:	First Name	Title:	
Last Name:	Last Name		
Relationship to Subscriber:	Dependent		
Gender:	Gender	Social Security Number:	SSN
Subscriber ID:	Subscriber ID	Date of Birth:	DOB

[Add a Family Member](#)

# ENROLL A NEW MEMBER SUMMARY



Group/Employer Information <span>Edit</span>	
Employee Number:	Department Number:
Employee Status: <b>Active</b>	Hire Date: <b>10-25-2021</b>
Desired Effective Date: <b>11-01-2021</b>	

Subscriber Information	Family Member Information
First Name: First Name	<b>Spouse</b> <span>Delete</span> <span>Edit</span>
Last Name: Last Name	First Name: First Name Title:
Gender: Gender	Last Name: Last Name
Date of Birth: DOB	Relationship to Subscriber: Spouse
	Gender: Gender
	Gender: Social Security Number: XXX-XX-XXXX
	Date of Birth: DOB
	<a href="#">Add a Family Member</a>
	<b>Persons Covered:</b> Excellus Plan Name
	Subscriber Name <input checked="" type="checkbox"/>
	Dependent Name <input checked="" type="checkbox"/>
	<b>Medicare Information</b> <span>Edit</span>
	Do you or your family members have Medicare coverage? <b>No</b>
	<b>Other Coverage Information</b> <span>Edit</span>
	Have you or any of your family members had <b>No</b> coverage under another health or dental insurance carrier during the last 63 days?

If everything is correct, please click 'Submit'. To make any changes, use the 'Edit' links above. Submit

Verify that all dependents have a green check mark for coverage. Otherwise, the dependents will not be covered



# ENROLL A NEW MEMBER CONFIRMATION

- You can use the **Recent Submissions** feature to view a record of this transaction
- There are options to **Print or Save as PDF** here as well

## Confirmation

### Submission Receipt

✔ Thank You! Your application for First Name \_Last Name was received.

Depending on any additional enrollment requirements, your transaction will be processed within 3 to 5 business days.

Your confirmation number is: 2021-10-29 15:05:08.265117

ID Entered: Member SSN

⚠ Please print or save this receipt and keep a copy of the signed application for your records.

 [Print Enrollment Form](#)

 [Save Enrollment Form as PDF](#)

# VIEW RECENT SUBMISSIONS



# VIEW RECENT SUBMISSIONS

Excellus  Employers Q Search ? Get Help

Home **Enroll & Update** Compare Plans Billing Data Reporting Resources

## Enroll & Update

- Group**
  - New Group Paperwork
  - Renewal Group Paperwork
  - Annual Group Information Form
  - Add/Activate/Remove Group Number
  - Summary of Benefits and Subscriber Contracts
- Member**
  - Enroll a New Member
  - View Member Roster
  - View/Update Policy
  - Reinstate Cancelled Policy
  - Member Card
  - View Deductible
  - Recent Submissions**

**1. ENROLL & UPDATE**  
**2. RECENT SUBMISSIONS**



**Enroll New Member**  
Enroll new members.



**View Member Roster**  
View a list of active, terminated, and pending subscribers.



**View/Update Policy**  
Make changes to, look up subscribers, and update policies.



**Reinstate Member**  
Reinstate previously inactive Members.



**Member Card**  
Order new Member Cards or print Temporary Proof of Coverage.



**Enroll and Billing Support**  
Submit enrollment and billing inquiries.



**Forms**  
View and print copies of our most frequently used forms.



**Contact Us**  
Questions? Find ways to contact us through email, telephone and in person.

# RECENT SUBMISSIONS

## Recent Submissions

Search Options

From:   To:

Subscriber ID/SSN:

Subscriber Last Name:

[Additional Instructions](#)

**Search for Recent Submissions by:**  
Date Range  
*OR*  
Subscriber Information



**Additional Instructions**

- Click a column heading to sort results.
- Once processed, you can view these changes in our Member Roster.

# VIEW RECENT SUBMISSIONS

Select Subscriber Name to view details of the enrollment transaction

Transaction Types include:

- Cancel Coverage
- Enroll New Member
- Change Coverage
- Add Dependent

Subscriber Name	Subscriber ID/SSN	Transaction Type	Status	Date Entered
Jane Doe	XXXXXXXXXX	Cancel Coverage	Received	11-03-2021
John Doe	XXXXXXXXXX	Cancel Coverage	Received	11-02-2021
Donald Duck	XXXXXXXXXX	Cancel Coverage	Received	11-02-2021
Clark Kent	XXXXXXXXXX	Enroll New Member	Received	11-02-2021
Minnie Mouse	XXXXXXXXXX	Enroll New Member	Received	11-01-2021

# RECENT SUBMISSIONS – MORE DETAILS

## Recent Submissions

### Cancel Coverage Confirmation

[« Return to Previous Page](#)

Confirmation Number: 2021-11-03 09:22:52.705598

[Print This Page](#)

Subscriber Name: Subscriber Name

ID Assigned: Subscriber ID

#### Group/Employer Information

Employee Number:	Employee Number	Department Number:	Department Number
Employee Status:	Employee Status	Desired Effective Date:	Desired Effective Date

#### Subscriber Information

First Name:	First Name	Title:	
Last Name:	Last Name		
Gender:	Gender	Date of Birth:	DOB

#### Address Information

Street Address:	Street Address	Daytime Phone Number:	Phone Number
City:	City	Email Address:	Email
State/Province:	State		
Zip/Postal Code:	Zip Code	Country:	Country

#### Family Member Information

Persons Covered: Excellus Blue PPO Signature Copay 1 15/25/150



# CONTACT US





Employers

**Under the Employers Tab, select "Get Help"**

Search

**? Get Help**

Login/Register

**Please Note:** We've updated our website to resolve a few issues. If you continue to experience issues, you will need to clear your browser cache. Need help? See [How to Clear Your Cache](#)

# Resources for a Healthier Team

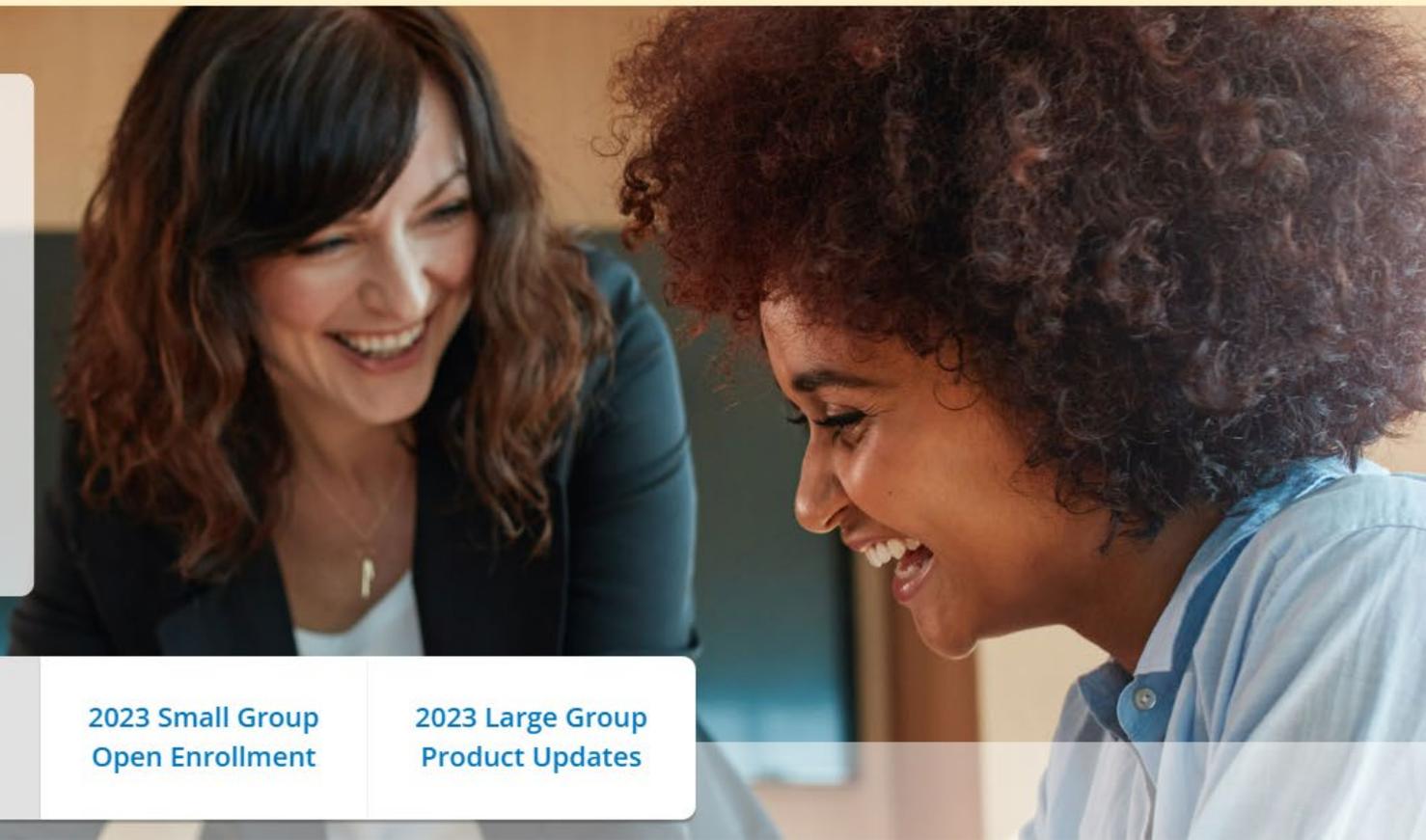
Download free resources to help employees get the most out of their health plan.

**Visit ExcellusForBusiness**

Resources for a Healthier Team

2023 Small Group Open Enrollment

2023 Large Group Product Updates



# Contact Us

- Email
- Phone
- Mail
- Visit Us In-Person

Follow these links to send a private, secure message to us. Our representatives will respond within **four b** telephone.

[Enrollment Inquiry & Support Tool](#)

**Enrollment Inquiry and Support Tool:**  
**Use for**

- Name, date of birth, SSN changes
- Reinstates beyond the 31 days
- Questions

*Must be logged in to access*  
*Allow 4 business days for response*

**i** Log in and use the Enrollment & Inquiry Support tool to send all inquiries to our Enrollment team. SSL encryption ensures that the information transmitted remains secure.

**i** Check Out Our Process for [Enrollment Inquiry & Support](#)

*For more information about the Enrollment Inquiry and Support Tool, open the attached PDF*

If you do not have online account or need access to additional online features, it's easy!

Register or create an account or request access today !

- Select the type of access you need:
  - Enrollment and Account Maintenance
  - Online Bill Pay
  - Annual Group Information Form
- Complete all fields; click 'Submit'
- Requests are typically completed within 3-5 business days.

[Add or Remove Group Numbers for Online Enroll & Update](#)

**To Add/Remove or Activate Group Numbers fill out this e-form**

- Prescription Drug Help Desk
- Web Training/Support
- Technical Website Issues

# ENROLLMENT INQUIRY & SUPPORT TOOL

## Contact Us

Email

Phone

Mail

Visit Us In-Person

### How to Submit a Case:

Log In to account, then select link  
"Enrollment Inquiry and Support Tool"

Follow these links to send a private, secure message to us. Our representatives will respond within **four business days**. If you need an immediate response, please call by telephone.

[Enrollment Inquiry & Support Tool](#)

Log in and use the Enrollment & Inquiry Support tool to send all inquiries to our Enrollment team. SSL encryption ensures that the information transmitted remains secure.

Check Out Our Process for [Enrollment Inquiry & Support](#)

If you do not have online account or need access to additional online features, it's easy!

[Register or create an account or request access today!](#)

# CREATE NEW CASE

## Enrollment Inquiry & Support

**DASHBOARD**

If you have any questions regarding your case, please contact your dedicated Account Service Consultant.

+ Create New Case

**My Cases**

**From**

03-04-2023

**To**

06-02-2023

Q Search

## FORM

[< Return to Previous Page](#)

### \* Required Fields

Please provide as much information as you can then click 'Agree and Submit' at the bottom of the form. We protect the privacy of your message with [SSL Encryption](#).

Your Name \*

Your Phone \*

Extension

Your Email \*

Your Role \*

Group Administrator  Broker of Record

Case For \*

Individual Market  Group Market

**Enter Name, Phone, Email**  
*(will pre-populate)*

**Choose Role : Group Administrator**  
**Case For : Group Market**

**Product \***

**Reason for Inquiry \***  
 [View Details](#)

**Group Number(s) \***

**Group Number not listed ?**

Group Number (8 digits) OR Group Number with Subgroup (12 digits). Click + icon for additional entries

**Multiple or Individual Subscriber(s) \***  
 Multiple  Individual  N/A ?

**Choose Product : Commercial**

**Choose Reason for Inquiry**  
 (View Details for more guidance)

**Choose Group Number(s)**  
 From those already associated to account  
 OR  
 Add Group # that is not listed

**Choose Multiple or Individual**  
 (only choose multiple if request pertains to multiple subscribers, not including dependents)

Subscriber Name \* ?

Subscriber ID \*



***Enter Subscriber Information***

Each individual may have one or more subscriber IDs related to a medical, dental or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.

### Attach Files Below

Click "Select" to browse and add your documentation. Accepted file types: .pdf, .doc, .docx, .jpeg, .xls, .tiff

Documents Attached

Yes  No

***Attach any supporting documentation***

How can we help you? \*

***Tell us about your request/question***

Agree and Submit

Cancel

Print

# CONFIRMATION

**Your case has been submitted successfully.** Your case ID is ABC-1234 . If you have any questions regarding your case, please contact your dedicated Account Service Consultant.

**Your case has been submitted.  
Keep your Case ID for reference  
Allow 4 business days for response**

# CHECK CASE STATUS

**You can also track case submissions from the Enrollment Inquiry and Support Tool page**

**My Cases**

From  To

Show  entries Search:

< **1** 2 >

CASE ID	REASON FOR INQUIRY	DATE SUBMITTED	LAST UPDATED DATE	GROUP NUMBER(S)	SUBSCRIBER NAME	STATUS
	Eligibility Maintenance	05/18/2023	05/31/2023			Pending-ProcessorReview

# BY PHONE

*For Technical Website Issues, please call our Web Help Desk*

## Contact Us

By Email

By Phone

By Mail

Visit Us In-Person

FOR QUESTIONS ABOUT:

Commercial Large Group (50 or more eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations

Commercial Small Group (Less than 50 eligible subscribers) Benefits, Setup, Updates, Cancellations, Billing, Member Enrollment or Member Cancellations

Technical Website Issues

Member Claims, Benefits or Authorizations for Medical, Dental or Pharmacy Plans

CONTACT:

Call your dedicated Broker and/or Account Service Consultant

Call your dedicated Broker and/or Account Service Consultant

Call our Web Help Desk at **1-800-278-1247**  
(Monday - Friday, 9 a.m. to 4:30 p.m. EST)

Members should call the **number on their Member ID Card.**

Excellus 

  
**Everybody Benefits**

**THANK  
YOU**