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HIOS ID#: 78124NY1000073-00

EC: SIII

Group Health Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included
- This application cannot be processed without this information and a signature

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

_____ Medical Group Number (8 digits)

_____ Medical Subgroup Number (4 digits)

_____ Medical Class Number (4 digits)

_____ Dental Group Number

_____ Dental Subgroup Number

_____ Employer Name

_____ Association/Chamber Name (if applicable)

_____ Group Administrators Signature

_____ Date

Subscriber Status:

☐New Hire - Date of Hire: ___ /___ /____

☐Rehire- Date of Rehire: ___ /___ /____

☐COBRA - Effective Date: ___ /___ /____

☐Retired - Effective Date: ___ /___ /____

☐Cancelled -- Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Subscriber

☐Dependent Reached Max Age ☐ Other: _____

Section 2: Your Information

This section should be completed by the Subscriber

_____ Last Name _____ First Name _____ MI _____ Social Security #**

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

_____ Street Address _____ City _____ State _____ Zip

_____ Billing Address (if different) _____ City _____ State _____ Zip

_____ Phone

_____ Email

Would you like to receive emails about health & wellness? ☐ Yes No☐

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced/Marital Status Event Date ___/___/_____

Section 3: Subscriber Medical Plan Selection

SimplyBlue Plus Gold 9

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/_____

Section 4: Subscriber Dental Plan Selection

Please select plan if applicable:

☐Dental Blue Classic
☐Dental Blue Options
☐Dental Other

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)
☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/_____

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage ☐COBRA
☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance
☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage
☐Address Change ☐Last Name Change ☐A move in or out of service area
☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other _____

Date of Event ___/___/_____

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber
☐Medical Coverage ☐Dental Coverage ☐Both Cancelation Effective Date ___/___/_____
☐Dependent(s) (List each dependent below in section 7)
☐Medical Coverage ☐Dental Coverage ☐Both Cancelation Effective Date ___/___/_____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage
☐Coverage through spouse ☐Loss of eligibility through employer or discontinuation of employer coverage
☐Other _____

Section 7: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child *Separate form required
☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child *Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: M ☐ F ☐ Birthdate ___/___/_____

_____ _____ _____
Last Name (if different) First Name MI Social Security #**

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

Note: Use an additional application if more than five people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No
If yes, are you keeping the coverage? ☐Yes ☐No Other insurance carrier name:_____
If no, when will the coverage cancel? __/__/__
Policyholder's name _____ ID# _____
Effective Date: ___/___/____
Who did the insurance cover? ☐Self Only ☐Self & Child (ren)
☐Self & Spouse/Domestic Partner ☐Family

Section 9: Release – You must sign and date this form to be eligible for health 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_____

If you have questions, please contact your Group Administrator.
Or, visit us at:
ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1
This section should be completed by a Group Benefits Administrator.

Section 2
This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 3
Column A – This column is populated with the plan name your group has selected.
Column B – Select who you want to cover on this medical plan.

Section 4
Column A – Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.
Column B – Select who you want to cover on this dental plan.

Section 5
Select the box that describes what you need to do regarding health insurance coverage and include the date of the event. 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 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.

You may be required to provide documentation of certain events.

Section 6
If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 7
Please include information about all the people who you would like coverage for.
Use an additional application if more than five people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (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 including natural, adopted or stepchild(ren)
- Child (ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

** We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 8
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 9

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

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 out-of-network benefit that 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.