Excellus
P.O. Box 21146, Eagan, MN 55121
A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

Instructions on Back. All Dates = mm/dd/yy ❑ **Check if name change** ❑ **Check if new address** **Please print clearly.**

✓ CHECK DESIRED ACTION

❑ **Add** Subscriber (AA)
Date of Hire/Event ___ / ___ / ___
Coverage Eff Date ___ / ___ / ___

❑ **Add** Dependent (AB)
Date of Event ___ / ___ / ___
Coverage Eff Date ___ / ___ / ___

❑ **Change** Coverage (AC)
Coverage Eff Date ___ / ___ / ___

❑ **Transfer** to COBRA (AD)
❑ (S)ubscriber
❑ (M) Dependent
❑ (D)isabled
Date of Event ___ / ___ / ___

❑ **Cancel** Subscriber (S)
❑ **Cancel** Dependent (M)
❑ (M)edical
❑ (D)ental
❑ (V)ision
Reason Code (see back)_____
Cancellation Date ___ / ___ / ___

✓ CHECK DESIRED MEDICAL/DENTAL/VISION COVERAGE

Classic Blue
❑ Regionwide (KC)
❑ BlueCross (KA)
❑ BlueCross BlueShield (KB)
❑ BCBS and Enhanced Benefits (KC)
❑ BlueCross Select (KS)
❑ Comprehensive (KD)
❑ BCBS Comprehensive (CO)
❑ Comprehensive Plus (CP)
❑ BCBS Traditional (TR)
❑ BCBS Wraparound (WR)

❑ BluePoint 2 (SF)
❑ Blue Choice 25 (BZ)
❑ Blue Choice 30 (BW)
❑ HMOBlue 25 (MZ)
❑ HMOBlue 30 (MW)

❑ PPO (PN)
❑ Excellus BluePPO (BP)
❑ Excellus BlueEPO (BE)
❑ FourFront (EF)
❑ BluePPO/HSA (HF)
❑ BluePPO Savings Account Plan (DC)

❑ Dental **(DE)**____ ❑ Vision **(VI)** ____

✓ CHECK PERSON(S) COVERED

	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
MEDICAL	❑	❑	❑	❑
DENTAL	❑	❑	❑	❑
VISION	❑	❑	❑	❑

SUBSCRIBER INFORMATION - Must be completed

Social Security # |_|_|_| — |_|_| — |_|_|_|_| Sex: ❑ M ❑ F Birthdate ___ / ___ / ___

Last Name_____ First_____

Street_____

City_____ State_____ Zip_____

Day Phone: |_|_|_|-|_|_|_|-|_|_|_|_| E-Mail Address:_____

Blue Choice members must select a Medical Center or Primary Care Physician (PCP). Females may select an Ob/Gyn.

Check Medical Center: ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton Current Patient?

Primary Provider (Last)_____ (First)_____ ❑ Y ❑ N

OB/GYN Provider (Last)_____ (First)_____ ❑ Y ❑ N

FAMILY MEMBER INFORMATION ✓ **Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.**

❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Domestic (P)artner ❑ Other_____ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Last First Current patient? ❑ Y ❑ N OB/GYN Physician Last First Current patient? ❑ Y ❑ N
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disable ❑ (F)oster/Grandchild Dependent ❑ Domestic (P)artner ❑ Other_____ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Last First Current patient? ❑ Y ❑ N OB/GYN Physician Last First Current patient? ❑ Y ❑ N
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Domestic (P)artner ❑ Other_____ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Last First Current patient? ❑ Y ❑ N OB/GYN Physician Last First Current patient? ❑ Y ❑ N
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ (F)oster/Grandchild Dependent ❑ Domestic (P)artner ❑ Other_____ *Last Name (if different)* *First Name*	Social Security #	Sex ❑ M ❑ F	Birthdate (mm/dd/yy) ___/___/___	Medical Center ❑ (W)ilson ❑ (F)olsom ❑ (G)reece ❑ (P)erinton	Primary Care Physician Last First Current patient? ❑ Y ❑ N OB/GYN Physician Last First Current patient? ❑ Y ❑ N

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.
Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
❑ Yes ❑ No ✓ Check: ❑ Medical and/or ❑ Dental Are you keeping this coverage? ❑ Yes ❑ No
✓ Check previous insurance company from list below and indicate ID #:_____
❑ (B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice.
❑ (O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name:_____
❑ (C) Other Carrier - Indicate Plan Name:_____

RELEASE - 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**_____

EMPLOYER INFORMATION (Must be completed by Group Administrator) *Deductible Amt., Dept. # and Employee # is optional.

Was the employee subject to a waiting period before enrolling in your employer health plan? ❑ Yes ❑ No
If yes, what was the start date ___/___/___ and end date ___/___/___

Coverage	Group/Sub Group #	Chk digit	Pkg #	Deductible Amount*	Employer Name
Medical				. 0 0	Employee Status ❑ (A)Active ❑ (A)COBRA ❑ **(A)Cancellation** ❑ (R)etired
Dental				. 0 0	Department #* Employee #*
Vision				. 0 0	Group Rep Signature/Date

Instructions for completing the Group Enrollment Form

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of 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 Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

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

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible
PC – Preferred Care
CP – Commercial
CB - Cobra Begin Date
CD - Cobra Disabled Date
CE - Cobra End Date
SR – Subscriber Request
SD – Subscriber Deceased
SB - Spouse's BCBSRA
MC - Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA - Marriage
OA - Dependent Over Age
DM - Deceased
MB - COBRA Begin Date
MR - Subscriber Request
DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- Address
- Birthdate
- PCP
- OB/GYN
- Medical Center

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Administrator.

PCP Information

Blue Choice members must select a **Medical Center OR Primary Care Physician (PCP).** Females may select an OB/GYN.

FAMILY MEMBER AND DOCTOR INFORMATION Use an additional form, if more than four persons.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
  - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.** Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate 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 accept 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 understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.
- **BLUE CHOICE**
  I understand that if I have elected a managed care product that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**
  I understand that the Preferred Provider Organization (PPO) coverage is comprised of and 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.
- **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.

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

If you have any questions, please contact Customer Service at:
Excellus BlueCross BlueShield, Rochester Region (585) 325-3630 or 1-800-847-1200
Blue Choice Member Services (585) 454-4810 or 1-800-462-0108

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Child Health Plusמעמבער אדער Managed Medicaid, ביטע רופט 1-800-650-4359. מעמבער, ביטע רופט 1-877-626-9298. אלע אנדערע ביטע רופט Essential Plan אויב איר זענט אן 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Child Health Plus أو Managed Medicaid ، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan ، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid اگر آپ 1-800-650-4359 پر کال کریں۔ ممبر ہیں تو براہ کرم Essential Plan1- کے ممبر ہیں تو براہ کریم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.