Excellus

165 Court Street, Rochester, NY 14647
An Independent Licensee of the
BlueCross BlueShield Association

GROUP TRADITIONAL MEDICARE ELIGIBLE ENROLLMENT FORM

IF ACTIVELY EMPLOYED - STOP ! !
See back.

DO NOT USE - MICROFILM USE ONLY

Instructions on Back.

Please print clearly.

✓ CHECK DESIRED ACTION

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

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

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

✓ CHECK DESIRED COVERAGE

MEDICAL
❑ Complementary (CM)
❑ Retiree Health Plan (RE)
❑ Comprehensive (CO)

DENTAL/VISION
❑ Dental (DE) _____
❑ Vision (VI) _____

✓ CHECK TYPE COVERAGE

	Self (D)
MEDICAL	❑
DENTAL	❑
VISION	❑

SUBSCRIBER INFORMATION - Must be completed

❑ Check if name change ❑ Check if new address

Social Security # |__|__|__| - |__|__| - |__|__|__|__| Sex: ❑ M ❑ F Birthdate ___ / ___ / ___

Last Name (Self) _____ First _____

Street _____

_____

City _____ State _____ Zip _____

Day Phone: |__|__|__| - |__|__|__| - |__|__|__|__|

Spouse's Social Security # _____ – _____ – _____

MEDICARE ELIGIBILITY

Medicare Health Insurance (Claim Number): _____ – ____ – _____ Check one: ❑ Over 65 ❑ Disabled

Effective Date: Part A (Hospital) ____ / ____ / ____ Effective Date: Part B (Medical) ____ / ____ / ____

If not eligible for Medicare Part A, give reason: _____

_____

"THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US."

OTHER COVERAGE INFORMATION - Must be completed.
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 health insurance policy in the last 63 days (including Medicare or Medicaid)? ❑ Yes ❑ No
Are you keeping this coverage? ❑ Yes ❑ No **If no, complete Cancel Date Eff Date ___/___/___ **Cancel Date ___/___/___
Check Insurance Company Name from the list below:
❑ (B) Excellus BlueCross BlueShield, Rochester Region
❑ (O)ther BlueCross BlueShield Plan Name
_____
❑ (P)referred Care
❑ Other (C)arrier (Name/Address)
_____

Policyholder Name _____
Policyholder # _____ SS # _____ – ____ – _____
Employer Name _____
Insurance Company Phone ____–____–_____
Coverage: ❑ (M)edical - Includes CHIP, ValuMed & Medicaid ❑ (D)ental ❑ (V)ision
Persons Covered: ❑ (S)ingle ❑ (F)amily ❑ Family (N)o Spouse

COMPLEMENTARY AND RETIREE HEALTH PLAN
The coverage applied for provides limited benefits health insurance only. This coverage does not meet the minimum requirements for Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the State of New York. Purchase of this coverage may be unnecessary, if you already have or intend to purchase Medicare supplement insurance or long term care insurance.

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 Representative)** *Optional

Coverage	Group/Sub Grp #	Chk Digit	Pkg #	Ded Amt*	Employer Name
Medical				. 0 0	Employee Status ❑ (A)ctive ☑ (R)etired
Dental				. 0 0	Department #* Employee #*
Vision				. 0 0	Group Rep Signature/Date

White Copy: Excellus BlueCross BlueShield, Rochester Region • Yellow Copy: Employer

B-775 3/03

Instructions for completing the Group Traditional Medicare Eligible Form

ACTIVELY EMPLOYED OR DISABLED APPLICANTS
If you are actively employed complete the appropriate Group Enrollment Form. If you are actively employed and eligible for Medicare, see your Group Representative to determine eligibility for Tefra/Defra or Obra. If eligible, complete the appropriate election form.

DESIRED ACTION
Check the appropriate action and indicate the Date(s) in the space provided. If Add Subscriber or Change Coverage, you must also check Desired Coverage and Desired Person covered. An event date is the date of specific occurrence, due to change in status, marriage, divorce, birth, group's anniversary date or rate change. Your request must be received within 60 days of the event.

Cancel Request
To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet – OR –**

To Cancel a 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
SD - Deceased
SR - Subscriber Request
PC - Preferred Care
CP - Commercial
SB - Spouse's BCBSRA

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

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

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 acknowledgment 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 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 six (6) month waiting period for pre-existing conditions unless prior coverage affords credits for some or all of this time period.

If you have any questions, please contact Customer Service at:
(585) 325-3630 or 1-800-847-1200