ENROLLMENT INQUIRY TRAINING GUIDE



Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association





CONTENTS

Overview of Forms

Review of Forms

Dashboard Review

Creating a New Case

Market Segment: Commercial Group

Market Segment: Medicare Employer/Union Group

Submitting a Case





Overview of Forms

Process	
New Add	Enrollment Applica
Adding Dependent	Enrollment Applica
QMCSO	Court order, <u>QMC</u> is not already enro
QMCSO Disenrollment	QMCSO Disenrol
Custodial Parent	Court order, comp if dependent is no
Disabled Dependent	Adult Disabled De enrolled or becom
Key Employee	Enrollment Application required information Enrollment and M

Documentation Needed

ation

ation

- SO Certification Form, completed application if dependent olled.
- Iment Form, and court order
- pleted Enrollment Application ot already enrolled.
- ependent Form Application, if dependent is not already nes disabled prior to maximum age of contract.
- ation, letter on company letterhead. Letter must contain ion, refer to your Group Administrator's Guide under laintenance procedures.



Process	
Student Certification	Enrollment Applicat
Demographic Change	Enrollment Applicat section of request
Cancel	Enrollment Applic
Reinstate	 If within 30 days for application. Enter If over 30 days from needed
Medicare	<u>Medicare form</u> or <u>E</u>
COBRA	Enrollment Application employer group or the COBRA benefit

Documentation Needed

tion, Student Certification Form

tion or enter action needed in the Additional Details

ation or Membership Cancel Worksheet

from cancellation date, okay to reinstate without a new action needed in the Additional Details section of request om the cancellation date, a new Enrollment Application is

nrollment Application

tion and COBRA Form is to be provided by either the Lifetime Benefit Solution (LBS) based on who is managing



New Add Required Fields Enrollment Forms Overview





POS/HMO – Requires Primary Care Physician (PCP)

Excellus Commercial Group H Please print clearly and complete	Tealth Insurance Applik ete all sections that apply. Signatu	cation/Cha	Inge Form	HIOS ID#	CONFIDENTIA d on Page 4.	L	
Section 1: Employer G	roup & Benefit Informati	On To be con Association/C	npleted with you Dhamber Name (if a	r Group Admin Che Ipplicable)	istrator ck Desired Action kdd Cancel Chan	9e	On
Group Administrator's Signature (r	equired) Date		Employee Marine	Dep	partment Number		
Medical Information	Who's covered?	subscriber Status:	Dental Infor	mation wh	o's covered? of Only		pro
Medical Group Number (8 digits)	□Self & Spouse/Domestic Partner □Family	Working Retired	Dental Group Nur	tber DS	elf & Spouse/Domestic Part amily	ner	er
Autoroup Class	Medical Effective Date	Conceled COBRA	Subgroup Class Dental Plan	De	ntal Effective Date		
Please choose plan options to	om dropdowns			oose pari opoor		1	De
			Vision Inform	mation Wh	o's contered? In Only of & Child(ren) of & Spouse/Domestic Part	ner	
			Subgroup Class	Vis	ion Effective Date		Only
			Vision Plan S	Selection	a from dropdowns		you a
Section 2: Subscriber's	Information						depe
Last Name		Birthdate: Gender: Female Male Gender X	Gende Trar Trar	r identity (op isgender Male isgender Ferr er to self-des	tional): Prefer not to s e Non-binary ale cribe:	ay	<u> </u>
First Name		Social Securi	ty Number**				
Middle Initial Title (e.g., 3	r, Sr, III, etc.)	Date of Hire/	Rehire:				
Street Address			Retirement D	ate:	□Age 65+ □Disabi	╧	
		Subscribe	or's Medicare Nu	mber (if applica	End Stage Renal *	l Ir	ns is r
City	State	•					
City	State	Medicare	Part A Effective D	ate Medicar	e Part B Effective Date		you a

ly fill out the oduct you are nrolling into (Medical, ental, Vision)

required if are adding ndents

needed only if are a female he age of 19

			Sub	scriber's Last Name:	
Section 3: Reason for en	rollment or	change Tobec	ompleted by the Gro	up Administrator Not re	quired for cancelations
inrollment Opportunity: 🗆	New Hire	Rehire Ope	n Enrollment	Medicare eligible	
Special Enrollment Opports	unity: 🗆 🗆 N	ewly Eligible Depe	ndent: Newbor	n ⊡Marriage ⊡Oti	er
Change in employment statu Involuntary loss of coverage	IS DA	move in or out of ormer dependent r	the service area equins eligibility	Date of Event	
ORPA Election - Please in	dicate the re	acon for CORPA	if applicable:	_	
Left Employment/Retired	Divorce/L	egal Separation	Loss of Stud	ent Status D	eath of Spouse
Demographic Change: Ad	dress 🗆 Birt	hdate Subscrit	ber Name ODe	pendent Name	Phone Number
Section 4: Cancel Inform	nation - If c	anceling cover	age, who are	you canceling cov	erage for?
Cancel Ce	de: Medi	ical Cancel Date:	Dental Cance	Date: Vision Ca	ncel Date:
oubscriber			t		
ancel Codes: 802-Left Employment SB58-C	hange in Emplo	vee Elicibility Status	S808-Subaroup	Transfer*	
806-Employee No Longer Wants	Coverage* (subs	ober requet)	SBS7- Layoff Wit	hout Benefits	* - Not eligible for COBRA
807-Deceased SB09-E	nrolled in Error	SB44-Medicare I	Eligible (Hoved to Hedio	re plat with same employer)	
Pependent(s) Name	: Cano	el Code: Medica	Cancel Date:	Dental Cancel Date:	Vision Cancel Date
- Not eligible for colletta					
and Coder					`
002-Deceased* M005-Divorced	M010-Overage	e Decendent M014-Y	A No Looper Quali	fiest M013-Ineliab	e Dependent
003-Subscriber No Longer Wants	to Cover Depe	ndent* M007-0	Rependent No Long	er Wants Coverage*	M009-Marriage
011-No Longer a Student	M004-Enroller	d in Error* M008-M	foved Out of Area*	M040-Medicar	re Same Group*
Section 5: Information a	bout who y	ou would like o	coverage for (dependent inform	nation)
Section 5: Information a	bout who y	nt Child Child Child	coverage for (Isabled Depende	dependent inform	nation) m required)
Section 5: Information a	bout who y	nt Child Child Child	coverage for (isabled Depende	dependent inform nt (Separate application for	nation) rm required)
Section 5: Information a	bout who y	nt Child I Adult D	coverage for (isabled Depende	dependent inform nt (Separate application fo	nation) rm required)
Section 5: Information a	Title First	t Name	isabled Depende	dependent inform nt (Separate application fo Social Security Numb	nation) m required) Her **
ast Name (if different)	Title First	t Name Birthdate	isabled Depende	dependent inform nt (Separate application fo Social Security Numb	nation) rm required) xer **
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male G iender Identity (spassa) Transge	Title First	t Name Birthdate	isabled Depende MI	dependent inform nt (Separate application fo Social Security Numb fer not to say □Prefer to	nation) m required) er ** self-describe:
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) Gender: Female Male Gender identity (splease) Transge a dependent a full-time student over a f yes, please provide name of college	Title First	t Name Birthdate	Non-binary IPre	dependent inform It (Separate application for Social Security Numb fer not to say □Prefer to Expected Graduation Dat endent further education at	nation) rm required) xer ** self-describe: e: ,
Section 5: Information a Spouse Domestic Partner Other ast Name (If different) iender: Female Male G iender identity (spissed) Transge i dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No	Title First inder Male T age 197 Title If v	t Name Birthdate No Married? ENo C	Non-binary Pre	Social Security Numb for not to say Prefer to Expected Graduation Dat endent further education at Disability DE	nation) m required) Her ** self-describe:
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) Gender: Female Male Gender Identity (spouse) Transge dependent a full-time student over a yes, please provide name of college Medicare Eligible Tyes No	Title First	t Name Birthdate Transpender Female Transpender Fem	Non-binary Phe Will dep	Social Security Numb for not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Dat	nation) m required) wer ** self-describe:
Section 5: Information a Spouse Domestic Partnes Other ast Name (if different) Gender: Female Male G Gender identity (splesal) Transge a dependent a full-time student over a f yes, please provide name of college fedicare Eligible Yes No fedicare Number (if applicable)	Title First iender X nder Male T age 197 Tytes D (university If y Part	t Name Birthdate Birthdate No Married? No S s, indicate reason t A Effective Date:	Non-binary Pre	dependent inform It (Separate application for Social Security Numb for not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da	nation) m required) er ** self-describe: e:,, fter graduation? □Yes □N nd Stage Renal * te:
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male G iender identity (spissed) Transport dependent a full-time student over a yes, please provide name of college fedicare Eligible Yes No fedicare Number (if applicable)	Title First	t Child Adult D t Child Adult D t Name Birthdate ranspender Female C No Married? No C es, indicate reason t A Effective Date:	Non-binary Pre Will dep	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da	nation) m required) m required) m required self-describe:
ast Name (if different) ender: Female Male Content dependent a full-time student over a yes, please provide name of college ledicare Eligible Yes No edicare Number (if applicable) imary Care Physician's Last Name	Title First Curiversity First Name	t Name Birthdate ranspender Female	Non-binary Phe Non-binary Phe Non-binary Will dep Age 65+	dependent inform It (Separate application for Social Security Numb for not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame First Name	nation) m required) er " self-describe: fter graduation? □Yes □N nd Stage Renal * ite: Zip Code
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male G iender identity (spissed) Transge i dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No Redicare Number (if applicable) rimary Care Physician's Last Name	Title First Title First iender X age 197 EVes E (university	t Child Adult D t Child Adult D t Name Birthdate ranspender Female No Married? No E es, indicate reason t A Effective Date: 	Non-binary Pre Will dep Age 65+	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame First Name	nation) m required) wer ** self-describe: for graduation?YesN nd Stage Renal * te: Zip Code
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male G iender identity (spissed) Transge dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No Redicare Number (if applicable) imary Care Physician's Last Name	Ibout who y IDependes III Dependes III Part IIII PART III PART III PART IIII PART IIII PART III PART IIII	t Name Birthdate Transpender Female Transpender Female Transpender Female Transpender Female Transpender Female Transpender Temale Transpender Tem	Non-binary Pre Will dep Age 65+	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame First Name	nation) m required) wer ** self-describe: for graduation? =Yes =N nd Stage Renal * te: Zip Code
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male C iender identity (spissel) Transpe i dependent a full-time student over a yes, please provide name of college fedicare Eligible Yes No fedicare Number (if applicable) rimary Care Physician's Last Name Dependent Child Adult D	Title First age 197 UYes D (university	t Name Birthdate Int Child Adult D Int Child Adu	Coverage for (Isabled Depende MI Non-binary □Pre I'res Gb/Gyn's Last N pendent(s) ↓ ston form required) I	dependent inform It (Separate application fo Social Security Numb for not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame Prst Name Other	nation) m required) er ** self-describe: fter graduation? □Yes □N nd Stage Renal * fte: Zip Code
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) Gender (Inferent) Gender (Inferent) Gender (Inferent) Gender (Inferent) Gender (Inferent) Gender (Inferent) College Nedicare Eligible (Yes) No No Nedicare Number (If applicable) College Nedicare Physician's Last Name Dependent Child (Adult Di ast Name (If different)	Title First age 197 Title First funiversity First Name	t Name Birthdate Int Child Adult D Int Child Adu	Coverage for (Isabled Depender MI Non-binary □Pre I'res Will dep □Age 65+ Ob/Gyn's Last N pendent(s) ↓ Ition form required) I MI	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame Pirst Name Other Social Security Numb	Nation) Im required) Her ** Self-describe: ter graduation? □Yes □N nd Stage Renal * te: Zip Code Her **
Section 5: Information a Spouse Domestic Partner Other ast Name (If different) iender: Female Male G iender identity (spissed) Transge dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No ledicare Eligible Yes No ledicare Number (If applicable) imary Care Physician's Last Name Dependent Child Adult D ast Name (If different) iender: Female Male G	Title First First Name Title First Sender X age 197 TYes D (university If y Part First Name Sabled Depeny Title First	t Name Birthdate No Mamed? No S Since Second	Coverage for (Isabled Depende MI Non-binary □Pre ires Will dep □Age 65+ Ob/Gyn's Last N pendent(s) ↓ tion form required) I MI	dependent inform It (Separate application fo Social Security Numb Iter not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame First Name Other Social Security Numb	Nation) Im required) Her ** Self-describe: E:
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) Gender (Female Male Ge Gender Identity (splanat) Transport (yes, please provide name of college fedicare Eligible Yes No fedicare Number (if applicable) fimary Care Physician's Last Name Dependent Child Adult D ast Name (if different) iender: Female Male Ge iender Identity (splanat) Transport iender: Female Male Ge iender Identity (splanat) Transport	Title First age 197 Title First (university First Name First Name Title First Sender X nder Male T	t Name Birthdate Tanspender Female Tappender Birthdate Tappender Birthdate Tappender Birthdate B	Coverage for (Isabled Depender MI Non-binary □Pre Pres Will dep Ob/Gyn's Last N pendent(s) ↓ Ition form required) D MI Non-binary □Pref	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame Pirst Name Other Social Security Numb fer not to say Prefer to	Nation) Im required) Her ** Self-describe: Ter graduation? □Yes □Ne nd Stage Renal * te: Zip Code Her ** Self-describe:
Section 5: Information a Spouse Domestic Partner Other ast Name (If different) iender: Female Male G iender identity (spissed) Transge dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No ledicare Eligible Yes No ledicare Number (If applicable) imary Care Physician's Last Name Dependent Child Adult D ast Name (If different) iender: Female Male G iender identity (spissed) Transge idependent a full-time student over a set Name (If different)	Title First age 197 Title First sender X university First Name First Name Title First Gender X isabled Depen Title First	t Name Birthdate In Child □Adult D Adult D Birthdate In Married? No I So Married? No I Des, indicate reason t A Effective Date: Zip Code ↓ Additional De dent (Separate applica dent (Separate applica In Married? No I	Coverage for (Isabled Depende MI MI Non-binary □Pre ires Ob/Gyn's Last N pendent(s) ↓ don form required) [MI Non-binary □Pre MI	dependent inform It (Separate application fo Social Security Numb It not to say Prefer to Expected Graduation Dat Disability E Part B Effective Da ame First Name Other Social Security Numb Iter not to say Prefer to Expected Graduation Date Iter not to say Prefer to Expected Graduation Date Iter not to say Iter at a security Numb Iter not to say Iter at a security	Ner ** Self-describe: Ter graduation?YesN nd Stage Renal * te: Zip Code Her ** Self-describe: ter ==
Section 5: Information a Spouse Domestic Partne Other ast Name (if different) Gender: Female Male Ge Gender identity (spissal) Transpe is dependent a full-time student over a f yes, please provide name of college fedicare Number (if applicable) fimary Care Physician's Last Name Dependent Child Adult Di ast Name (if different) iender: Female Male Ge iender identity (spissal) Transpe is dependent a full-time student over a f yes, please provide rame of college is dependent a full-time student over a f yes, please provide rame of college is dependent a full-time student over a f yes, please provide rame of college is dependent a full-time student over a f yes, please provide rame of college for identity (spissal) Transpe for identity (spissal) Transpe f yes, please provide rame of college for identity (spissal) Transpe f yes, please provide rame of college for identity (spissal) Transpe f yes, please provide rame of college for identity (spissal) Transpe f yes, please provide rame of college f or identity (spissal) Transpe	bout who y IDepender Title Title First age 197 y Jage 197 Yes /university If y Part First Name Sabled Depender Title First Name Sender X Inder Male Title First Sender X Inder Male Title First Sender X Inder Male Title If y Sender X Inder Male If y Sender X Inder Male If y I	t Name Birthdate Tanspender Female Tanspender Female Tanspender Temale Tanspender Temale Tanspender Temale Tanspender Temale Tanspender Female Tanspender Female Tanspender Female Tanspender Female Tanspender Female Tanspender Temale Tanspender Te	Coverage for (Isabled Depende MI Non-binary □Pre Pres Ob/Gyn's Last N pendent(s) ↓ Itan form required) I MI Non-binary □Pref Pres Will dep	dependent inform It (Separate application for Social Security Numb It is say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Dat ame Pirst Name Other Social Security Numb Iter not to say Prefer to Expected Graduation Date endent further education at Disability Iter not to say Iter not to s	Nation) Im required) Her ** Self-describe: ter graduation?YesN nd Stage Renal * te: Zip Code Her ** Self-describe: ter graduation?YesN Ad Stage Renal *
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male G iender identity (spissed) fransge dependent a full-time student over a f yes, please provide name of college dedicare Eligible Yes No fedicare Number (if applicable) fimary Care Physician's Last Name Dependent Child Adult D ast Name (if different) fender: Female Male G fender identity (spissed) Transge dependent a full-time student over a f yes, please provide name of college dependent a full-time student over a f yes, please provide name of college dependent a full-time student over a f yes, please provide name of college dependent a full-time student over a f yes, please provide name of college dependent a full-time student over a f yes, please provide name of college fedicare Eligible Yes No	Title First age 197 Title First age 197 Title First First Name First Name Sender X isabled Depen Title First Sender X inder Male Ti age 197 Title First isabled Depen Title First isabled Depen Title First isable Jepen Title First	t Name Birthdate In Child ☐Adult D Birthdate In Birthdate In Married? ☐No I Birthdate Zip Code ↓ Additional De dent (Separate applica dent (Separate applica t Name Birthdate Ino Married? ☐No I So Married? ☐No I	Coverage for (Isabled Depende MI Non-binary □Pre Ires Will dep Ob/Gyn's Last N pendent(s) ↓ don form required) I MI Non-binary □Pre Will dep MI Non-binary □Pre	dependent inform It (Separate application fo Social Security Numt for not to say Prefer to Expected Graduation Dat endent further education at Disability Part B Effective Da ame First Name Other Social Security Numt for not to say Prefer to Expected Graduation Date endent further education af Disability Expected Graduation Date endent further education af Disability Expected Graduation Date endent further education af Expected Graduation Date end	hation) m required) ker ** self-describe: ter graduation?YesN self-describe: ter graduation?YesN nd Stage Renal *
Section 5: Information a Spouse Domestic Partner Other ast Name (if different) iender: Female Male Co iender identity (spissel) Transpe i dependent a full-time student over a fyes, please provide name of college fedicare Eligible Yes No fedicare Number (if applicable) timary Care Physician's Last Name Dependent Child Adult Di ast Name (if different) iender: Female Male Co iender identity (spissel) Transpe dependent a full-time student over a fyes, please provide rame of college dependent a full-time student over a fyes, please provide rame of college dependent a full-time student over a fyes, please provide rame of college fedicare Eligible Yes No fedicare Eligible Yes No fedicare Eligible Yes No	bout who y IDepender Title Title First age 197 y Part First Name Sender X nder Male Title First Name Sender X nder Male Title First Name Sender X nder Male Title First Sender X If y Sender X If y Part Sender X If y Part	t Name Birthdate In Child ☐Adult D Birthdate In Married? ☐No I So Married? ☐No I So Married? ☐No I Des, indicate reason t A Effective Date: Zip Code ↓ Additional De dent (Separate applica t Name Birthdate Ino Married? ☐No I So Married? ☐No I So Married? ☐No I So Married? ☐No I	Coverage for (Isabled Depender MI Non-binary □Pre Pres Qb/Gyn's Last N pendent(s) ↓ Itan form required) D MI Non-binary □Pref Non-binary □Pref Non-binary □Pref	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame Prist Name Other Social Security Numb fer not to say Prefer to Expected Graduation Data endent further education at Expected Graduation Data endent further education at Disability E Part B Effective Da	nation) million will self-describe: iself-describe: iself-describe: Zip Code will self-describe: Zip Code will self-describe: Zip Code will self-describe: Zip Code will self-describe: Yes self-describe: Self-
Section 5: Information a Spouse Domestic Partner Other ast Name (If different) iender: Female Male G iender identity (spissed) Transge dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No iedicare Number (If applicable) imary Care Physician's Last Name Dependent Child Adult D ast Name (If different) iender: Female Male G iender identity (spissed) Transge dependent a full-time student over a yes, please provide name of college dependent a full-time student over a yes, please provide name of college dependent a full-time student over a yes, please provide name of college Medicare Eligible Yes No iedicare Eligible Yes No	Title First age 197 Title First isabled Depender First Name Title First isabled Depender Title First	t Name Birthdate In Child ☐Adult D Birthdate Ino Married? ☐No I Ino Married? ☐No I	Coverage for (Isabled Depende MI Non-binary □Pre ires Ob/Gyn's Last N pendent(s) ↓ don form required) I MI Non-binary □Pre ives MI Non-binary □Pre ives MI	dependent inform It (Separate application fo Social Security Numt for not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame Prst Name Other Social Security Numt for not to say Prefer to Expected Graduation Dat endent further education af Disability E Part B Effective Dat ame Disability E Part B Effective Dat ame Disability E Part B Effective Dat	hation) m required) wer ** self-describe: ter graduation?YesN self-describe: ter graduation?YesN nd Stage Renal * ter graduation?YesN nd Stage Renal * ter graduation?YesN
iection 5: Information a Spouse Domestic Partner Other ast Name (if different) ender: Female Male G ender identity (upstand) Transge dependent a full-time student over a yes, please provide name of college ledicare Number (if applicable) imary Care Physician's Last Name Dependent Child Adult D ender: Female Male G ender identity (upstand) Transge dependent a full-time student over a yes, please provide name of college ledicare Eligible Yes No ender: Female Male G ender identity (upstand) Transge dependent a full-time student over a yes, please provide name of college ledicare Eligible Yes No ender identity (upstand) Transge dependent a full-time student over a yes, please provide name of college ledicare Eligible Yes No edicare Number (if applicable) imary Care Physician's Last Name	bout who y IDepender Title First iender X If y age 197 Yes /university If y First Name Title isabled Depender If y isable If y isable If y if y Part	t Name Birthdate In Child ☐Adult D Birthdate In Married? ☐No I In Married? ☐No I	Coverage for (Isabled Depender MI Non-binary □Pre Pres Ob/Gyn's Last N pendent(s) ↓ Itan form required) D MI Non-binary □Pref Non-binary □Pref Non-binary □Pref Non-binary □Pref	dependent inform It (Separate application for Social Security Numb fer not to say Prefer to Expected Graduation Dat endent further education at Disability E Part B Effective Da ame First Name Cother Social Security Numb fer not to say Prefer to Expected Graduation Data endent further education at Expected Graduation Data endent further education at Disability E Part B Effective Da ame First Name	Ner ** Self-describe: ter graduation? Tyes IN nd Stage Renal * Ite: Zip Code Ser ** Self-describe: Ter graduation? Tyes IN nd Stage Renal * Ite: Ter graduation? Tyes IN nd Stage Renal * Ite: Type Code



Dependent Child Adult Disabled Dependent (Separate application form required)		
		Instructions for completing the Group Health Insurance Application/Change Form
Last Name (I' different) Title First Name MI Social Security Number ** Gender: Female Male Gender X Birthdate Gender identity (optional): Transgender Male Inon-binary Prefer not to say Prefer to self-describe:		Section 1: Employer Group & Benefit Information This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical, dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.
Is dependent a full-time student over age 197 TYES No Marned? No Yes Expected Graduation Late: If yes, please provide name of college/university Will dependent further education after graduation? TYES Medicare Eligible TYES No If yes, indicate reason Age 65+ Disability End Stage Renal * Part A Effective Date: Part B Effective Date: Medicare Number (If applicable) Primary Care Physician's Last Name First Name Zip Code Ob/Gyn's Last Name First Name Code Note: Use an additional application or addendum if more than three dependents need coverage Section 6: Other coverage information (Required) - You may be contacted for additional information Have you or any member of your family been enrolled in other medical or dental coverage? Tyes No If yes, what type of coverage? Medical Dental What is the effective date of the other coverage? Medical: Dental:	Only complete if other coverage is applicable.	 Section 2: Subscriber's Information 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. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form. Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this <u>optional gender identity section</u> of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.
What is the name of the other carrier? Are you keeping the coverage? Yes If no, when will the coverage end? Medical: Policyholder's name ID#(s) Who did the insurance cover? Self Only Self & Spouse/Domestic Partner Self & Child(ren)		Section 3: Reason for enrollment or change Select the box(es) that describe(s) the reason for this enrollment or change 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. You may be required to provide documentation of certain events.
Section 7: Release - You must sign and date this form to be eligible for health insurance 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		Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for? If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.
and information. I make this acknowledgement and agreement on behalf of myself and each other person who 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. 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. HEALTH MAINTENANCE ORGANIZATION (HMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provide (PCP) who will provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. POINT OF SERVICE (POS) I understand that the Point of Service (POS) plan provides services on two benefit levels: In-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provide (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. I have thoroughly read, understand and agree to comply with the terms of the release in this section. 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 suc		 Section 5: Information about who you would like coverage for (dependent information) Please include information about all the people who you would like coverage for. Use an additional application or addendum if more than three dependents 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 county clerk) 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 disabled dependent who is over the maximum 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. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form. A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.
Subscriber Signature Date		Section 6: Other coverage information (Required) Please include accurate information in this section. This could affect the processing of your application and/or claims.
Please return to P.O. Box 21146 Eagan, MN 55121-0146 If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com	1	Section 7: Release Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.
APP-352 (0723) E Mid/Large Group Page	3	APP-352 (0723) E Mid/Large Group



PPO/EPO/Indemnity – No Primary Care Physician (PCP)

Excellus 🗟				FOR INTERNAL US		
Commercial Group H Please print clearly and comple Section 1: Employer Gr	ealth Insurance App te all sections that apply. Signa oup & Benefit Informa	lication/Cha atures are required ation To be cor	ange Form d. Additional instr npleted with you	CONF ructions included on Page 4 r Group Administrator	IDENTIAL	Only
Employer Name		Association/	Chamber Name (E	Check Desired	hoel 🖬 Change	prod
Group Administrator's Signature (re	quired) Date		Employee Numbe	r Department Nur	nber	enr
Aedical Information	Ealf Only Self & Child(ren) Self & Spouse/Domestic Parts Family	Subscriber Status: Actively Ner Working Retired	Dental Infor	mation Self Ock Self Ock Self & Child(re Self & Spouse)	n) Domestic Partner	(Med
Andical Plan Selection	Medical Effective Date	Canceled	Subgroup Class Dental Plan	Dental Effect Selection	ive Date	١
Please choose plan options to	m dropdowns		Please ch	cose plan options from dropp		
			Vision Infor	mation Set Only	0	
			Vision Group Nur	iber Self & Spouse	Domestic Partner	Only
			Subgroup Class Vision Plan S	Vision Effecti Selection	ve Date	if
				cose pan options from dropor		a
Section 2: Subscriber's	Information	Birthdate:				dep
Last Name		Gender: Female Male Gender X	Gende Trai Trai	er identity (optional): Insgender Male Insgender Female Ver to self-describe:	efer not to say on-binary	· · ·
First Name		Social Secur	ity Number**			
Middle Initial Title (e.g., 3r,	Sr, III, etc.)	Date of Hire	/Rehire:		-	
Street Address			Retirement D	ate:	S+ □Disability	
City	State	Subscrib	er's Medicare Nu	mber (if applicable)	age kendi *	
Zip Code	Phone	_				
PP-352 (0723) E Mid/Laure Gro	10				Page 1	

fill out the uct you are olling into ical, Dental, Vision)

y required you are adding pendents

		Subsc	riber's Last Name:	
Section 3: Reason for enrollm	ent or change To be co	ampleted by the Grou	p Administrator Not r	required for cancelations
Enrollment Opportunity: New H	re □Rehire □Ope	n Enrolment 🛛 🗆	Medicare eligible	_
Special Enrollment Opportunity:	Newly Eligible Deper	ndent: Newborn	□Marriage □0	ther
Change in employment status Involuntary loss of coverage	A move in or out of Former dependent r	the service area egains eligibility	Date of Event	
COBRA Election - Please indicate	the reason for COBRA	if applicable:		
Left Employment/Retired Di Disability De	vorce/Legal Separation pendent Reached Max Ag	Loss of Stude Other:	nt Status	Death of Spouse
Demographic Change: Address	Birthdate Subscrit	ber Name 🛛 🗇 Dep	pendent Name 👘 🕻	Phone Number
Section 4: Cancel Information	- If canceling covera	age, who are y	ou canceling co	verage for?
Subscriber Cancel Code:	Medical Cancel Date:	Dental Cancel	Date: Vision C	ancel Date:
Cancel Codes:				
SB02-Left Employment SB58-Change i	n Employee Eligibility Status	S808-Subgroup Tr	ransfer*	
SB06-Employee No Longer Wants Covera SB07-Deceased SB09-Enrolled	in Error* S844-Medicare I	Eligible (Moved to Medcan	out benefits plat with same employer)	* - Not eligible for COBON
Dependent(s) Name:	Cancel Code: Medica	Cancel Date:	Dental Cancel Date	Vision Cancel Date:
pependent(s)				
* - No elgos to costa				1
				•
Cancel Codes:	Oversee Dependent M014-Y	A No Longer Cupits	est M013-Joeloi	ble Denendent
M003-Subscriber No Longer Wants to Cov	er Dependent* M007-C	ependent No Longe	" Wants Coverage"	M009-Marriage
M011-No Longer a Student M004	Enrolled in Error* M008->	loved Out of Area*	M040-Medic	are Same Group*
Section 5: Information about	who you would like o	coverage for (d	lependent infor	mation)
Spouse Domestic Partner De	ependent Child Adult D	isabled Dependen	t (Separate application f	form required)
Last Name (if different) Title	First Name	M	Social Security Num	uber **
Sector Change Children Constant	Black date		and a second rate	
Gender identity (unsues) Transgender Ma	le Transgender Female C	Non-binary Prefe	r not to say CPrefer	to self-describe:
Is dependent a full-time student over age 197	Ties No Married? No I	Tes	Expected Graduation D	te:
If yes, please provide name of college/universit	ty	Will depe	ndent further education	after graduation? Yes No
Medicare Eligible Yes No	If yes, indicate reason	□Age 65+	Disability D	End Stage Renal *
	Part A Effective Date:		Part B Effective D	ate:
Medicare Number (if applicable)				
	🔶 Additional De	pendent(s) 🔶		
Dependent Child Adult Disabled	Dependent (Separate applica	tion form required) 🗆	Other	
	a de a cara a factar ara dela se			
Last Name (# different) Title	First Name	M	Secial Security Num	they **
carc manne (il cinierent)			Security Hair	
Gender: UPemale UMale UGender) Gender identity (setimet: UTransporter Ma	Birthdate	Non-binary ElPrefe	r not to say	n self-describer
Is dependent a full-time student over and 192	Wer The Married? The	Ver.	Reported Graduation Dr.	
If yes, please provide name of college/universit	Y	Will deper	dent further education a	after graduation?
Medicare Eligible Yes No	If yes, indicate reason	□Age 65+	Disability D	End Stage Renal *
	Part A Effective Date:		Part B Effective D	ate:
Medicare Number (if applicable)				



Subscriber's Last Name:		
Dependent Child Adult Disabled Dependent (Separate application form required) Other		Instructions for completing the Group Health Insurance Application/Change Form
Last Name (f different) Title First Name MI Social Security Number ** Gender: Female Male Gender X Birthdate Image: Control of the security Number ** Gender identity (optional): Transgender Female Non-binary Prefer not to say Prefer to self-describe: Is dependent a full-time student over age 19? Yes No Married? No Expected Graduation Date:	Only	Section 1: Employer Group & Benefit Information This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical, dental and/or vision group numbers and information must be populated. Select who you need coverage for on the medical dental and/or vision plan(s). Next, select the medical, dental and/or vision plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator. Indicate the subscriber's status.
If yes, please provide name of college/university Will dependent further education after graduation? If yes Medicare Eligible Yes If yes, indicate reason Age 65+ Disability End Stage Renal * Medicare Number (if applicable) Part A Effective Date: Part B Effective Date: If yes, indicate reason Note: Use an additional application or addendum if more than three dependents need coverage Part A	complete if other	Section 2: Subscriber's Information 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. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form. Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, coorder expression or behavior. In order to ensure that you are receiving access to bish quality, affordable bealth care
Section 6: Other coverage information (Required) - You may be contacted for additional information Have you or any member of your family been enrolled in other medical or dental coverage? Yes No If yes, what type of coverage? Medical Dental What is the effective date of the other coverage? Medical: Dental: What is the name of the other carrier?	coverage is applicable.	based on your individual needs, we ask that you consider completing this <u>optional gender identity section</u> of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.
Are you keeping the coverage? Yes No If no, when will the coverage end? Medical: Dental: Policyholder's name ID#(s) Who did the insurance cover? Self Only Self & Spouse/Domestic Partner Self & Child(ren) Family Section 7: Release - You must sign and date this form to be eligible for health insurance		Select the box(es) that describe(s) the reason for this enrollment or change 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. You may be required to provide documentation of certain events.
I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is coverage 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 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 represent that all information furnished by me hereon is true and complete to the best of my knowledge. 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. HALTH MAINTENANCE ORGANIZATION (MMO) I understand that I have elected a Health Maintenance Organization (HMO) plan and that I am required to choose a Primary Care Provider (PC) who will provide my primary care, oversee my other health care services, and, when required, obtain provides services on two benefit levels: in-retwork or out-of-network benefits. I understand that the in-network benefit provides the highest level of overage under the plan and that I mait choose a Primary Care Provider (PC) be provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care. I have thoroughly read, understand and agree to comply with the terms of the release in this section. 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 insuran		 Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for? If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled. Section 5: Information about who you would like coverage for (dependent information) Please include information about all the people who you would like coverage for. Use an additional application or addendum if more than three dependents 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 county clerk) 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 overage. There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum 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 Alfordable Care Act. * There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate forms.
Please return to P.O. Box 21146 Eagan, MN 55121-0146 If you have questions, please contact your Group Administrator. Or, visit us at: Excellus8CBS.com		Section 6: Other coverage information (Required) Please include accurate information in this section. This could affect the processing of your application and/or claims. Section 7: Release Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.
APP-352 (0723) E Mid/Large Group Page	e 3	APP-352 (0723) E Mid/Large Group Pa

How to Access the Enrollment Inquiry & Support Dashboard





Visit www.excellusbcbs.com















			bull winkle Account Settings Log Out
			Q Search ? Get Help
5	Billing	Commissions & Reporting ~	Resources 🛩
spo	nd within f	four business days. If you need a	in immediate response, please call by telephone.
Enn	oliment tea	am. SSL encryption ensures that t	he information transmitted remains secure.





To access a tip, click "Enrollment Inquiry & Support

H	ome 🛛 Enroll & Update 🐱	Compare Plans ~	Billing Com	mission
Brokers > Contact Us				
Contact Us				
Follow these links to send a private.	secure message to us. Our	epresentatives will resc	ond within four bu	isiness (
Enrollment Inquiry & Support Tool				
O Log in and use the Enrollment	& Inquiry Support too to ser	d all inquiries to our Er	rollment team. SSL	.encryp
Check Out Our Process for Englishing	ollment Inquiry & Support			
If you do not have a login today, it	t's easy to request one:			
Go to broker.excellusbcbs.co	om/registration			
 Select the appropriate option 	n			
 Complete all fields; click 'Sub Your request will be completed 	bmit' ted within 24-48 hours			
General Broker Inquiries		WT		
 Add or Kemove Group Number Prescription Drug Help Deck 	ers for Unline Enrollment & Bi	ming		

& Reporting Resources ~

days. If you need an

tion ensures that the

ENROLLMENT INQUIRY SUPPORT TOOL PROCESS



Tips on how to use the process

The purpose of this tool is to streamline all your eligibility maintenance requests, enrollment inquiries, billing/reconciliation requests, and other support requests. By submitting your inquiries and requests via this tool, they are securely transmitted directly to the request management system that is utilized to assign and process requests within our Enrollment department.

Security

You will need to log in prior to using the Enrolment inquiry & Support tool. When submitting requests, the took will auto populate certain fields based on the user's profile. The form itself utilizes Secure Sockets Layer (SSL) technology (the industry standard for secure transactions) to transmit the information to our request management system.

Completing the Form

The most common reason for an inquiry is likely to be Eligibility Maintenance. This reason for inquiry should be chosen for subscribec/member activity, new enrollments, and member additions to an existing contract, changes, terminations, etc.

All appropriate peperwork must accompany the request and required fields must be completed.

If retroactive review is required, please reference the Retroactive Process Tip Sheet, and include a completed Exception Request Form.

Attachments

Please be sure that all selected attachments are uploaded to the request prior to clicking the "agree and submit" button.

Attach your documentation. Depending on the browser and version being used, attachment functionality may very slightly. Web browsers such as Google Chrome allow multiple attactiments to be submitted on the same request. Certain browsers may only allow one attachment. If your browser has an "upload" button, be sure to fully upload the attachments. TO THE RIVERS







Creating a New Case





The Dashboard can be used to locate previously submitted cases and create new requests.





15

Below is the form that will appear after clicking "+ Create a New Case" you will be brought to this page. Fill out the required fields (*).

	Excellus 🗟 👽	Home	Enroll & Update 🐱	Compare P
FORM				
< Return to I	Previous Page			
* Required Fie	lds			
Please provide	as much information as v	ou can the	n click 'Agree and Subm	it' at the bott
Your Name *	as moon moon as y	ou can ore	In since register and a second	
		Þ		
Your Phone *	Extension		6	
Phone Numi	ber ID	p		
Your Email *				
	<u>.</u>	Þ		
Vour Bala #				
Group Adv	ninistrator 🔿 Brokor o	I Borord		
O Group Acr		4 Necora		
Case For *				
⊖ Individual	Market 🔘 Employer G	roup Mari	cet	
Market Segm	ent *			
-Please Selec	ct-		~	







Case For: Employer Group Market

Select Your Role option based on your applicable role as either the Group Administrator or Broker of Record

In the Case For field select Employer Group Market.

In the Market Segment field select either "Commercial Group Health Insurance" or "Medicare Employer/Union Group Health Plan"

NOTE: In the Case For field Individual Market is for direct pay plans only. Employer groups should not be using this option. It is an option for our Brokers of Record when enrolling through the Exchange. In these instances, the option to select under Market Segment would be Qualified Health Plan Individual & Family Health Insurance

Your Role *

Group Administrator O Broker of Record

- Case For *
- Individual Market O Employer Group Market

Market Segment *

Commercial Group Health Insurance

-Please Select-

Qualified Health Plan Individual & Family Health Insurance

Commercial Group Health Insurance

Medicare Employer/Union Group Health Plan Group Numper(s) *





Market Segment: **Commercial Group Health Insurance**

	Excellus 💇 🕅 Home E	nroll & Update 🗸 🛛 Compare Plans 🗸 🛛 Billing
	Your Email *	
	chinmay.joshi@excellus.com	
Select	Your Role * O Group Administrator O Broker of Record Case For * O Individual Market O Employer Group Market	Then select the Reas Inquiry from the dropdown.
Commercial	Market Segment *	
Group Health	-Please Select-	
Insurance	-Please Select-	
under Market	Commercial Group Health Insurance Medicare Employer/Union Group Health Plan	Action Needed *
Sogmont	With rease servere	-Please Select-
Segment	Group Number(s) *	
	Search Group Number	
	Group Number not listed 😏 📑	
	Enter Group Number	
	Group Number (8 digits) OR Group Number with Subgroup (12	digits). Click + icon for additional entries
	Subscriber First Name	Subscriber Last Name
	Subscriber First Name D	Subscriber Last Name







Commercial Group Health Insurance Reason for Inquiry:

Eligibility Maintenance





Action Needed: Add new subscriber/policyholder

Reason for Inquiry *		Action Needed *		
Eligibility Maintenance	~ 🛈 View Deta	Add new subscriber/policyh	older ~	
Group Number(s) *		If the group number does not appear	in the listing	
Search Group Number		manually add it under "Group Numbe Ability to add up to four (4) group nun	not listed." nbers.	
Group Number not listed 😧	+		The Action Needed requ	ires these elements when filling
Enter Group Number			out the paper Enrollme	nt Application being attached:
Group Number (8 digits) OR Group Num	ber with Subgroup (12 digits)	. Click + icon for additional entries	Group Name	Group Number
Subscriber First Name* 📀	5	ubscriber Last Name *	Effective Date	Subscriber Name
Subscriber First Name	[* 1	Subscriber Last Name	Subscriber DOB	Subscriber Gender
Plan(s)	Action Effective	e Date *	Plan Selection	Class
Medical	MM-DD-YYYY		Subgroup	Qualifying Event
			Dependent Information	Relationship
Dental	MM-DD-YYYY		Dependent Name	
D BY Only	MM-DD-YYYY		 Dependent Gender Dependent DOB 	
Vision	MM-DD-YYYY	#	Other Coverage Informati (If applicable)	on Group Administrator Signature



Action Needed: Add or change coverage for a dependent

Reason for Inquiry *			Action Needed *	
Eligibility Maintenance	~	View Details	Add or change coverage for a dependent	~
Group Number(s) *				շիդ
Search Group Number				0
Group Number not listed 🔞	+			
Enter Group Number				
Group Number /9 digital OB Group Numb	or with Subori	oun (12 digits) Click + icon for additional entrie	5	
aroup Muniper (8 digits) OK Group Munip	ier with Subgri	ap (12 algie), eler i reon or additional entre		
Subscriber First Name * 3	ALL MILL DUDGI	Subscriber Last Name *	Action Effective Date *	
Subscriber First Name * ③	¦I	Subscriber Last Name *	Action Effective Date *	those elements wh
Subscriber First Name * 3 Subscriber First Name	l¦i	Subscriber Last Name * Subscriber Last Name	Action Effective Date *	these elements wh
Subscriber First Name * ③ Subscriber First Name	1 1	Subscriber Last Name * Subscriber Last Name	Action Effective Date * The Action Needed requires to paper Enrollment Ap	these elements wh oplication being att
Subscriber ID * Subscriber ID	l¦i •	Subscriber Last Name * Subscriber Last Name	Action Effective Date * The Action Needed requires to paper Enrollment Ap Effective Date	these elements wh oplication being att Reason for Add
Subscriber ID * Subscriber ID Each individual may have one or mo	re subscribe	Subscriber Last Name * Subscriber Last Name	Action Effective Date * The Action Needed requires to paper Enrollment Ap Effective Date Subscriber Information	these elements who oplication being att Reason for Add Dependent Info
Subscriber First Name * ③ Subscriber First Name Subscriber ID * Each individual may have one or mo	re subscribe	Subscriber Last Name * Subscriber Last Name	Action Effective Date * The Action Needed requires to paper Enrollment Ap Effective Date Subscriber Information	these elements who oplication being att Reason for Add Dependent Info required to list
Subscriber First Name * ③ Subscriber ID * Subscriber ID Each individual may have one or mo Dependent First Name *	re subscribe	Subscriber Last Name * Subscriber Last Name	Action Effective Date * The Action Needed requires to paper Enrollment Ap Effective Date Subscriber Information	these elements who oplication being att Reason for Add Dependent Info required to list added)

nen filling out the ached:

ective Date	Reason for Adding
oscriber Information	Dependent Information (only
	required to list dependent beir
	added)
up Administrator Signature	Subscriber Signature





Action Needed: Reinstate or re-enroll a cancelled/termed policy

Reason for Inquiry *			Action Needed *		
Eligibility Maintenance	~ 🕄 View Det	ails	Reinstate or re-enroll a cancelled/termed pol	cy _h	
Group Number(s) *					
Search Group Number					
Group Number not listed 🔞	+				
Enter Group Number					
Group Number (8 digits) OR Group Numb	er with Subgroup (12 digits)). Click + icon for additional en	tries		
Subscriber First Name	S	ubscriber Last Name			
Subscriber First Name	1,1	Subscriber Last Name	;t		
Plan(s)	Action Effectiv	e Date *			
Medical	MM-DD-YYYY	曲			
			The Action Needed requi	res these elements when	filling
Dental	MM-DD-YYYY	**	out the paper Enrollme	nt Application being attac	
			out the puper Emonnie	ne, application being attac	ned.
BX Only					ned:
RX Only	MM-DD-YYYY	#	Group Administrator Signatu	re Qualifying Event	ned:
RX Only Vision	MM-DD-YYYY MM-DD-YYYY	##	Group Administrator Signatu Subscriber ID or Name	re Qualifying Event Effective Date	ned:





Action Needed: Cancel/terminate a subscriber/policyholder

Reason for Inquiry *			Action Needed -		
Eligibility Maintenance	~ (1)	View Details	Cancel/terminate a subscriber/policyholder	~	
Group Number(s) *					
Search Group Number					
Group Number not listed 🔞	+			6	
Enter Group Number Group Number (8 digits) OR Group Number	with Subgroup	(12 digits). Click + icon for additional entrie	25		
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name	with Subgroup	(12 digits). Click + icon for additional entrie Subscriber Last Name Subscriber Last Name	The Action Needed require	es these elements w	vhen filli
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name	with Subgroup	(12 digits). Click + icon for additional entrie Subscriber Last Name Subscriber Last Name	The Action Needed require out the paper Enrollmen	es these elements w t Application being a	vhen filli attached
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name Action Effective Date * MM-DD-YYYY	with Subgroup	(12 digits). Click + icon for additional entrie Subscriber Last Name Subscriber Last Name	The Action Needed require out the paper Enrollmen Group Name or Number	es these elements w t Application being a Cancel Effective D	vhen filli attached
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name Action Effective Date * MM-DD-YYYY	with Subgroup	(12 digits). Click + icon for additional entrie Subscriber Last Name Subscriber Last Name	The Action Needed require out the paper Enrollmen Group Name or Number Subscriber SSN or ID	es these elements w t Application being a Cancel Effective D Subscriber Name	vhen filli attached







Action Needed: Cancel/terminate a dependent

		Action Needed *		
Eligibility Maintenance	~ ③ View Details	Cancel/terminate a dependent	~	
Group Number(s) *				
Search Group Number				
Group Number not listed 🔞	+		\searrow	
Enter Group Number				
Group Number (8 digits) OR Group Number with S	Subgroup (12 digits). Click + icon for additional entri	es		
Subscriber First Name * 🔞	Subscriber Last Name *	Action Effe	ective Date *	
Subscriber First Name * ③ Subscriber First Name	Subscriber Last Name *	Action Effe	ective Date *	
Subscriber First Name * 3 Subscriber First Name	Subscriber Last Name * Subscriber Last Name	Action Effe	ective Date *	auires these elements when filling
Subscriber First Name * (?) Subscriber First Name Subscriber ID *	Subscriber Last Name * Subscriber Last Name	Action Effe	The Action Needed red out the paper Enrollr	quires these elements when filling ment Application being attached:
Subscriber First Name * ③ Subscriber First Name Subscriber ID * Subscriber ID Each individual may have one or more subscriber	Subscriber Last Name * Subscriber Last Name criber IDs related to a medical, dental or visio	Action Effe MM-DD-Y	ective Date * MYY The Action Needed red out the paper Enrollr Effective Date	quires these elements when filling ment Application being attached: Reason for Terming
Subscriber First Name * ③ Subscriber First Name Subscriber ID * Subscriber ID Each individual may have one or more subscriber	Subscriber Last Name * Subscriber Last Name criber IDs related to a medical, dental or visio Dependent Last Name *	Action Effe MM-DD-Y	ective Date * MYY The Action Needed real out the paper Enroll Effective Date Subscriber Information	quires these elements when filling ment Application being attached: Reason for Terming Dependent Information (only required to list dependent being
Subscriber First Name * ③ Subscriber First Name Subscriber ID * Subscriber ID Each individual may have one or more subs Dependent First Name * Dependent First Name	Subscriber Last Name * Subscriber Last Name criber IDs related to a medical, dental or visio Dependent Last Name * Dependent Last Name	Action Effe MM-DD-Y	ective Date * The Action Needed recout the paper Enrolline Effective Date Subscriber Information	quires these elements when filling ment Application being attached: Reason for Terming Dependent Information (only required to list dependent being termed)



Action Needed: Update demographic data for an existing member

Reason for Inquiry *			Acti
Eligibility Maintenance	~ (i) Vi	ew Details	Up
Group Number(s) *			
Search Group Number			
Group Number not listed 😗	+		
Enter Group Number			
Enter Group Number Group Number (8 digits) OR Group Numbe	er with Subgroup (1	2 digits). Click + icon for addition	nal entries
Enter Group Number Group Number (8 digits) OR Group Numbe Subscriber First Name	er with Subgroup (1	2 digits). Click + icon for addition Subscriber Last Nam	e entries
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name	er with Subgroup (1	2 digits). Click + icon for addition Subscriber Last Nam Subscriber Last Nam	e e
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name	er with Subgroup (1	2 digits). Click + icon for addition Subscriber Last Nam Subscriber Last Nam	e e
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name Action Effective Date *	er with Subgroup (1	2 digits). Click + icon for addition Subscriber Last Nam Subscriber Last Nam	e e
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Action Effective Date * MM-DD-YYYY	er with Subgroup (1	2 digits). Click + icon for addition Subscriber Last Nam Subscriber Last Nam	e e

Needed *

ate demographic data for an existing member

	The Action Needed red the paper Enrolln	quires these elements when filling out nent Application being attached:
р	Address Change	New addressSubscriber Information
n.	Subscriber Name Change	 Subscriber Information (including name change)
	Dependent Name Change	 Subscriber Information Dependent Information (including name change)
lick + icon to a	Birth Date Changes	 Subscriber Information (if applicable) Dependent Information (if applicable)
	Gender Changes	 Subscriber Information (if applicable) Dependent Information (if applicable)







Action Needed: Move to COBRA

Reason for Inquiry *		Action Needed *	
Eligibility Maintenance ~	③ View Details	Move to COBRA	- Junior - J
Group Number(s) *			
Search Group Number			
Group Number not listed 3			
Enter Group Number			
Subscriber First Name	Subscriber Last Name	The Action Needed requires out the paper Enrollment A	these elements when filling Application being attached:
Subscriber First Name	Subscriber Last Name	Group Administrator Signature	Subscriber Signature
Action Effective Date *		Effective Date	Subscriber ID or Name
MM-DD-YYYY		Group Name or Number	Subgroup
Subscriber ID *		Class	
Subscriber ID			
Each individual may have one or more subseri	her IDs related to a medical dental or visio	on policy. Click + icon to add additional subscriber.	ID(c) for the came individual



Action Needed: Add multiple new members to the same employer

Reason for Inqui	iry *		Action Needed *	
Eligibility Mainte	enance ~ ③ View	Details	Add multiple new members to the same e	employer ~
Group Number(s	s) *			
Search Group	Number		The Action Needed requires out the paper Enrollment /	these elements when filling Application being attached:
Group Number r	not listed 😨 🗧 🛨		Group Name	Group Number
Enter Group Nu	umber		Effective Date	Subscriber Name
Group Number (8 d	ligits) OR Group Number with Subgroup (12 d	gits). Click + icon for additional entrie	Subscriber DOB	Subscriber Gender
		_	Plan Selection	Class
	Application needed for		Subgroup	Qualifying Event
	each member being added to the same employer group.		Dependent InformationDependent NameDependent GenderDependent DOB	Other Coverage Information (If applicable)
			Relationship	Group Administrator Signature
			Subscriber Signature	





Action Needed: Update multiple members of the same employer

Eligibility Maintenance	Yiew Details
Group Number(s) *	
Search Group Number	
Group Number not listed 🔞	+
Enter Group Number	

Required fields depend on what needs to be updated



ional entries





Action Needed: Cancel/terminate multiple members of the same employer

Reason for Inquiry *			
Eligibility Maintenance	~	③ View Details	
Group Number(s) *			
Search Group Number			
Group Number not listed () Enter Group Number	+		
Group Number (8 digits) OR Group N	Number with Subg	group (12 digits). Click + icon fo	or additior
	For each canceled emp	nember being from the same	









Action Needed: Change plan

Eligibility Maintenance	~ (1)	View Details
Group Number(s) *		
Search Group Number		
Group Number not listed	• •	
Enter Group Number		
Enter Group Number Group Number (8 digits) OR Grou	up Number with Subgroup	(12 digits). Click + icon for additional e
Enter Group Number Group Number (8 digits) OR Grou Subscriber First Name	up Number with Subgroup	o (12 digits). Click + icon for additional e Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Grou Subscriber First Name Subscriber First Name	up Number with Subgroup	(12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Grou Subscriber First Name Subscriber First Name Action Effective Date *	up Number with Subgroup	o (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Grou Subscriber First Name Subscriber First Name Action Effective Date * MM-DD-YYYY	Ip Number with Subgroup	o (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Grou Subscriber First Name Action Effective Date * MM-DD-YYYY	Ip Number with Subgroup	o (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name

Action No	eeded *		
Change	plan	~	
	6		
- Г	The Action Needed requires	these elements w	hen fillin
	out the paper Enrollment A	Application being a	ttached:
- Г	Group Administrator Signature	Subscriber Signatur	e
	Effective Date	Subscriber ID or Na	me
	Group Name or Number		

policy. Click + icon to add additional subscriber ID(s) for the same individual.





Action Needed: I need help with something else

iceason for inquiry		Act	tion Needed *		
Eligibility Maintenance	~ (i) Vie	ew Details	need help with something els	se	t.
Group Number(s) *					
Search Group Number					
Group Number not listed 😨	+				
Enter Group Number					NUL DI CII
Enter Group Number Group Number (8 digits) OR Group Nur Subscriber First Name	nber with Subgroup (1	2 digits). Click + icon for additional entries Subscriber Last Name		5	Note: Please fill out all fields that include *
Enter Group Number Group Number (8 digits) OR Group Nur Subscriber First Name Subscriber First Name	nber with Subgroup (1	2 digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name	[]*1	ß	Note: Please fill out all fields that include *
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Subscriber First Name Action Effective Date *	nber with Subgroup (1	2 digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name	[* 1	ß	Note: Please fill out all fields that include *
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Subscriber First Name Action Effective Date *	nber with Subgroup (1	2 digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name	<pre>[#</pre>	2	Note: Please fill out all fields that include *
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Action Effective Date * MM-DD-YYYY Subscriber ID *	nber with Subgroup (1	2 digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name	[* 1		Note: Please fill out all fields that include *





Commercial Group Health Insurance Reason for Inquiry: Billing and Reconciliation





Action Needed: Question on my invoice

inclusion for inquity		Action Needed *	
Billing and Reconciliation ~	③ View Details	Question on my invoice	
Group Number(s) *			
Search Group Number			2
Group Number not listed 🕢 📑			
			Note: Diese
Enter Group Number			
Enter Group Number Group Number (8 digits) OR Group Number with Subg	roup (12 digits). Click + icon for additiona	entries	out all fields t
Enter Group Number Group Number (8 digits) OR Group Number with Subg	roup (12 digits). Click + icon for additiona	entries	out all fields t
Enter Group Number Group Number (8 digits) OR Group Number with Subg Subscriber First Name	roup (12 digits). Click + icon for additiona Subscriber Last Name	entries	out all fields t include *
Enter Group Number Group Number (8 digits) OR Group Number with Subg Subscriber First Name	roup (12 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name	entries I	out all fields t include *
Enter Group Number Group Number (8 digits) OR Group Number with Subg Subscriber First Name Subscriber First Name	roup (12 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name	l entries ¦t	out all fields t include *
Enter Group Number Group Number (8 digits) OR Group Number with Subg Subscriber First Name Billing Month * Billing Year * MM _ YYYY	Subscriber Last Name Subscriber Last Name	l entries	out all fields t include *
Enter Group Number Group Number (8 digits) OR Group Number with Subg Subscriber First Name Billing Month * Billing Year * MM YYYY Subscriber ID	Subscriber Last Name	l entries	out all fields t include *







Action Needed: Correct a payment allocation

A DOLLARD DE LE CONTRACTOR DE LA CONTRACTION DE LA CONTRACTIÓN DE LA CONTRACTICACIÓN DE LA CONTRACTICA			Action Needed *	
Billing and Reconciliation	•	③ View Details	Correct a payment allocation	~
Group Number(s) *				Im
Search Group Number				
Group Number not listed	•			
Cater Craue Number				
Enter Group Number				
Group Number (8 digits) OR G	roup Number with Subg	roup (12 digits). Click + icon for additional e	entries	Note: Please fi
Group Number (8 digits) OR G	roup Number with Subg	roup (12 digits). Cl <mark>ick</mark> + icon for additional e	entries	Note: Please fi out all fields tha
Group Number (8 digits) OR G	roup Number with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name	entries	Note: Please fi out all fields tha include *
Group Number (8 digits) OR G Subscriber First Name Subscriber First Name	roup Number with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name	entries *	Note: Please fi out all fields that include *
Group Number (8 digits) OR G Subscriber First Name Subscriber First Name Payment Date *	roup Number with Subg	roup (12 digits). Click + Icon for additional e Subscriber Last Name Subscriber Last Name	entries •	Note: Please fi out all fields tha include *
Composition of the second seco	roup Number with Subg	subscriber Last Name Subscriber Last Name	entries [¦t	Note: Please fi out all fields tha include *
Group Number (8 digits) OR G Subscriber First Name Payment Date * MM-DD-YYYY Subscriber ID	roup Number with Subg	subscriber Last Name Subscriber Last Name	entries I	Note: Please fil out all fields that include *







Action Needed: Request a refund

Billing and Reconciliation	~ 🛈 Vi	ew Details
Group Number(s) *		
Search Group Number		
Group Number not listed O		
Group Number not listed		
Enter Group Number		
Enter Group Number Group Number (8 digits) OR Group Num	nber with Subgroup (1	2 digits). Click + icon for additiona
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name	nber with Subgroup (1	2 digits). Click + icon for additiona Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name	nber with Subgroup (1	2 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Subscriber ID	nber with Subgroup (1	2 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name



or vision policy. Click + icon to add additional subscriber ID(s) for the same individual.





Action Needed: Request a copy of an invoice

Billing and Reconcil	iation	View D	Details
Group Number(s) *			
Search Group Num	nber		
Group Number not	listed 😧	+	
Enter Group Numb	er		
Group Number (8 digits)	OR Group Number wit	th Subgroup (12 dig	its). Click + icon for additiona
Group Number (8 digits) Subscriber First Nar	OR Group Number wit	th Subgroup (12 dig	its). Click + icon for additiona
Group Number (8 digits) Subscriber First Nar Subscriber First Na	OR Group Number wit	th Subgroup (12 dig	subscriber Last Name
Group Number (8 digits) Subscriber First Nat Subscriber First Nat Billing Month *	me me Billing Yea	th Subgroup (12 dig	Subscriber Last Name
Group Number (8 digits) Subscriber First Nat Subscriber First Nat Billing Month * MM	Me me Billing Yea	th Subgroup (12 dig	Subscriber Last Name
Group Number (8 digits) Subscriber First Nat Billing Month * MM Subscriber ID	me Billing Yea	th Subgroup (12 dig	Subscriber Last Name







Action Needed: Request a rebill

Billing and Reconcilia	tion ~	③ View De	etails
Group Number(s) *			
Search Group Numb	er		
Group Number not lis	ted 🖸 🗧 🕂		
Enter Group Number			
Group Number (8 digits) O	R Group Number with Subj	group (12 digit	s). Click + icon for additional
Group Number (8 digits) O Subscriber First Name	R Group Number with Subj	group (12 digit	s). Click + icon for additional Subscriber Last Name
Group Number (8 digits) O Subscriber First Name Subscriber First Name	R Group Number with Subj e	group (12 digit	s). Click + icon for additional Subscriber Last Name Subscriber Last Name
Group Number (8 digits) O Subscriber First Name Subscriber First Name Billing Month *	R Group Number with Subj e e Billing Year *	group (12 digit	s). Click + icon for additional Subscriber Last Name Subscriber Last Name
Group Number (8 digits) O Subscriber First Nam Billing Month * MM	e Billing Year *	group (12 digit	s). Click + icon for additional Subscriber Last Name Subscriber Last Name
Group Number (8 digits) O Subscriber First Nam Billing Month * MM Subscriber ID	R Group Number with Subj e Billing Year *	group (12 digit	s). Click + icon for additional Subscriber Last Name





Commercial Group Health Insurance Reason for Inquiry: Request Member ID Card



Action Needed: Request an ID Card

iceason for inquity		Action Needed *	
Request ID Card	~ ③ View Details	Request an ID card	
Group Number(s) *		ſŀm	
Search Group Number			
Group Number not listed 🕢	+		Note: Please
			out all fields t
Enter Group Number			
Enter Group Number Group Number (8 digits) OR Group Numb	er with Subgroup (12 digits). Click + icon for a	additional entries	include *
Enter Group Number Group Number (8 digits) OR Group Numb Subscriber First Name	er with Subgroup (12 digits). Click + icon for a Subscriber Las	dditional entries	include *
Enter Group Number Group Number (8 digits) OR Group Numb Subscriber First Name	ber with Subgroup (12 digits). Click + icon for a Subscriber Las Subscriber Las	additional entries t Name st Name	include *
Enter Group Number Group Number (8 digits) OR Group Numb Subscriber First Name Subscriber First Name	er with Subgroup (12 digits). Click + icon for a Subscriber Las Subscriber Las	additional entries t Name st Name	include *







Market Segment: Medicare Employer/Union Group Health Plan

	chinmay.joshi@excellus.com			
	Your Role * Group Administrator O Broker of Record Case For * Individual Market O Employer Group Market	Select the Reason for Inquiry from the dropdown.	Medicare Employer/Union Group H Request is related to Medicare employer/U	Health Plan
Select Medicare Employer/Union Group Health	Market Segment * -Please SelectPlease Select- Commercial Group Health Insurance Medicare Employment I plan Group Health Plan	- Action Needed *	Reason for Inquiry * -Please Select-	③ View Details
Plan under Market Segment	Group Number(s) * Search Group Number	-Please Select-	-Please Select- Eligibility Maintenance Billing and Reconciliation	3
	Group Number not listed Enter Group Number Group Number (8 digits) OR Group Number with Subgroup (12 dig	its). Click + icon for additional entries	Jouren oroup remou	
	Subscriber First Name	Subscriber Last Name		







Medicare Employer / Union Group Reason for Inquiry:

Eligibility Maintenance





Action Needed: Add new subscriber/policyholder

et at the training of the			
Eligibility Maintenance	~ (1)	/iew Details	Add
Group Number(s) *			
Search Group Number			
Group Number not listed	+		
Group Number not listed			
Enter Group Number			
Enter Group Number Group Number (8 digits) OR Group Num	mber with Subgroup	(12 digits). Click + icon for addi	tional entries
Enter Group Number Group Number (8 digits) OR Group Nur Subscriber First Name * 🚱	mber with Subgroup	(12 digits). Click + icon for addi Subscriber Last Na	tional entries
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name * ③ Subscriber First Name	mber with Subgroup	(12 digits). Click + icon for addi Subscriber Last Na Subscriber Last N	tional entries ame *
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name * (2) Subscriber First Name	mber with Subgroup	(12 digits). Click + icon for addi Subscriber Last Na Subscriber Last N Effective Date *	ame *
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name * ③ Subscriber First Name	mber with Subgroup	(12 digits). Click + icon for addi Subscriber Last Na Subscriber Last N Effective Date *	ame *

leeded *

w subscriber/policyholder

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Name	Group Number
Effective Date	Subscriber Name
Subscriber DOB	Subscriber Gender
Plan Selection	Class
Subgroup	Qualifying Event
 Dependent Information Dependent Name Dependent Gender Dependent DOB 	Relationship
Other Coverage Information (If applicable)	Group Administrator Signature
Subscriber Signature	





Action Needed: Reinstate or re-enroll a cancelled/termed policy

Eligibility Maintenance	~ 🛈 Vie	w Details
Group Number(s) *		
Search Group Number		
Group Number not listed 🔞	+	
Enter Group Number		
Group Number (8 aigits) OK Group Nun	nber with Subgroup (12	2 digits). Click + icon for additional
Subscriber First Name		Subscriber Last Name
Subscriber First Name	[]31	Subscriber Last Name
Subscriber First Name Subscriber First Name Plan(s)	Action Ef	Subscriber Last Name Subscriber Last Name
Subscriber First Name Subscriber First Name Plan(s) Medical	Action Ef	Subscriber Last Name Subscriber Last Name fective Date *
Subscriber First Name Plan(s) Medical RX Only	Li Action Ef MM-DD	Subscriber Last Name Subscriber Last Name fective Date * -YYYY
Subscriber First Name Plan(s) Medical RX Only Subscriber ID	Li Action Ef MM-DD MM-DD	Subscriber Last Name Subscriber Last Name fective Date * -YYYY

ction Needed *		
Reinstate or re-enroll a cancelled/termed policy		
b		
The Action Needed requires th	ese elements wh	en filling
out the paper Enrollment Ap	plication being at	tached:
Group Administrator Signature	Qualifying Event	
Subscriber ID or Name	Effective Date	
Group Name	Group Number	

policy. Click + icon to add additional subscriber ID(s) for the same individual.





Action Needed: Cancel/terminate a subscriber/policyholder

Eligibility Maintenan	ce	~ @v	iew Details
		0.	
Group Number(s) *			
Search Group Num	ber		
Group Number not li	sted 🕑	+	
Enter Group Numbe	r		
Enter Group Numbe Group Number (8 digits)	r OR Group Number	with Subgroup (12 digits). Click + icon for additiona
Enter Group Numbe Group Number (8 digits)	r OR Group Number	with Subgroup (12 digits). Click + icon for additiona
Enter Group Numbe Group Number (8 digits)	r OR Group Number	with Subgroup (12 digits). Click + icon for addition Subscriber Last Name
Enter Group Number Group Number (8 digits) Subscriber First Nam Subscriber First Nam	r OR Group Number ne	with Subgroup (12 digits). Click + icon for addition Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) Subscriber First Nam Subscriber First Nam	r OR Group Number ne ne	with Subgroup (12 digits). Click + icon for addition Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) Subscriber First Nam Subscriber First Nam Action Effective Date MM-DD-YYYY	ne me me me	with Subgroup (12 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) Subscriber First Nam Subscriber First Nam Action Effective Date MM-DD-YYYY Subscriber ID	ne te	with Subgroup (12 digits). Click + icon for additiona Subscriber Last Name Subscriber Last Name





Action Needed: Update demographic data for an existing member

Reason for Inquiry *		Action Needed *	
Eligibility Maintenance	 View Details 	Update demographic data for an existing	g member 🗸
Group Number(s) *			
Search Group Number			
Group Number not listed 🔞	+		
Enter Group Number			• • • • •
Group Number (8 digits) OR Group Number with S	ubgroup (12 digits). Click + icon for additional entri	the paper Enrol	equires these elements when Ilment Application being attac
Subscriber First Name	Subscriber Last Name	Address Change	New address
Subscriber First Name	Subscriber Last Name	1:1	Subscriber Information
Action Effective Date *		Subscriber Name	Subscriber Information (inc
MM-DD-YYYY		Change	name change)
Subscriber ID		Dependent Name	Subscriber Information
Subscriber ID		Change	 Dependent Information (in name change)
Each individual may have one or more subso	riber IDs related to a medical, dental or visio	^{n polic} Birth Date Changes	Subscriber Information (if a

filling out :hed:

Address Change	 New address Subscriber Information
Subscriber Name Change	 Subscriber Information (including name change)
Dependent Name Change	 Subscriber Information Dependent Information (including name change)
Birth Date Changes	 Subscriber Information (if applicable) Dependent Information (if applicable)
Gender Changes	 Subscriber Information (if applicable) Dependent Information (if applicable)





Action Needed: Add multiple new members to the same employer





Action Needed: Update multiple members of the same employer

Eligibility Maintenance	~	③ View Details
Group Number(s) *		
Search Group Number		
Group Number not listed 🔞	+	







Action Needed: Change plan

Eligibility Maintenance	~ (i) v	/iew Details
Group Number(s) *		
Search Group Number		
Group Number not listed 🔞	+	
Fature Course Mounthing		
Enter Group Number		
Group Number (8 digits) OR Group Numb	er with Subgroup	(12 digits). Click + icon for additional entr
Group Number (8 digits) OR Group Numb	er with Subgroup	(12 digits). Click + icon for additional entr
Group Number Group Number (8 digits) OR Group Numb Subscriber First Name	er with Subgroup	(12 digits). Click + icon for additional entr Subscriber Last Name
Group Number Group Number (8 digits) OR Group Numb Subscriber First Name Subscriber First Name	er with Subgroup	(12 digits). Click + icon for additional entr Subscriber Last Name Subscriber Last Name
Group Number (8 digits) OR Group Numb Subscriber First Name Subscriber First Name	er with Subgroup	(12 digits). Click + icon for additional entr Subscriber Last Name Subscriber Last Name
Subscriber First Name Subscriber First Name Action Effective Date * MM-DD-YYYY	er with Subgroup	(12 digits). Click + icon for additional entr Subscriber Last Name Subscriber Last Name
Subscriber ID Su	er with Subgroup	(12 digits). Click + icon for additional entr Subscriber Last Name

ction Needed *	
Change plan	~
	ſ

The Action Needed requires these elements when filling out the paper Enrollment Application being attached:

Group Administrator Signature	Subscriber Signature
Effective Date	Subscriber ID or Name
Group Name or Number	

olicy. Click + icon to add additional subscriber ID(s) for the same individual.



Action Needed: I need help with something else

Eligibility Maintenance	~	③ View Details
Group Number(s) *		
Search Group Number		
Group Number not listed 😡	+	
Enter Group Number Group Number (8 digits) OR Group Numbe	er with Subg	roup (12 digits). Click + icon for additional e
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name	er with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name	er with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name	er with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name Action Effective Date *	er with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Number Subscriber First Name Subscriber First Name Action Effective Date * MM-DD-YYYY Subscriber ID	er with Subg	roup (12 digits). Click + icon for additional e Subscriber Last Name Subscriber Last Name





Medicare Employer / Union Group **Reason for Inquiry: Billing and Reconciliation**



Action Needed: Question on my invoice

Billing and Reconciliation	~	③ View De	etails	
Group Number(s) *				
Search Group Number				
Group Number not listed	9 +			
Enter Group Number				
chief droup Number				
Group Number (8 digits) OR Gro	up Number with Sub	group (12 digit	s). Click + icon for additio	nal entrie
Group Number (8 digits) OR Gro	up Number with Sub	group (12 digit	s). Click + icon for additio	nal entrie
Group Number (8 digits) OR Gro Subscriber First Name	up Number with Sub	group (12 digit	s). Click + icon for additio Subscriber Last Nam Subscriber Last Nam	nal entrie ne
Group Number (8 digits) OR Gro Subscriber First Name Subscriber First Name	up Number with Sub	group (12 digit	s), Click + icon for additio Subscriber Last Nam Subscriber Last Nan	nal entrie
Group Number (8 digits) OR Gro Subscriber First Name Subscriber First Name Billing Month *	Billing Year *	group (12 digit	s), Click + icon for additio	nal entrie
Group Number (8 digits) OR Gro Subscriber First Name Billing Month * MM	Billing Year *	group (12 digit	s), Click + icon for addition	nal entrie





Action Needed: Correct a payment allocation

Billing and Reconciliatio	on ~ 🕤 Vie	w Details	Correct a payment allocation	~
Group Number(s) *				
Search Group Number				ß
Group Number not liste	ed 😧 🕂			
Enter Group Number				
Enter Group Number Group Number (8 digits) OR	Group Number with Subgroup (12	digits). Click + icon for additional entries		Note: Please fill
Enter Group Number Group Number (8 digits) OR	Group Number with Subgroup (12	digits). Click + icon for additional entries		Note: Please fill out all fields tha
Enter Group Number Group Number (8 digits) OR (Subscriber First Name	Group Number with Subgroup (12	digits). Click + icon for additional entries Subscriber Last Name		Note: Please fill out all fields tha include *
Enter Group Number Group Number (8 digits) OR (Subscriber First Name Subscriber First Name	Group Number with Subgroup (12	digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name		Note: Please fill out all fields tha include *
Enter Group Number Group Number (8 digits) OR Subscriber First Name Subscriber First Name Payment Date *	Group Number with Subgroup (12	digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name		Note: Please fill out all fields tha include *
Enter Group Number Group Number (8 digits) OR Subscriber First Name Subscriber First Name Payment Date * MM-DD-YYYY	Group Number with Subgroup (12	digits). Click + icon for additional entries Subscriber Last Name Subscriber Last Name		Note: Please fill out all fields tha include *
Enter Group Number Group Number (8 digits) OR Subscriber First Name Subscriber First Name MM-DD-YYYY Subscriber ID	Group Number with Subgroup (12	digits). Click + icon for additional entries Subscriber Last Name];1	Note: Please fill out all fields tha include *





Action Needed: Request a refund

Billing and Reconciliation	~ 🛈 VI	ew Details
Group Number(s) *		
Search Group Number		
Group Number not listed 😗	+	
Enter Group Number		
Enter Group Number Group Number (8 digits) OR Group Num	ber with Subgroup (1	2 digits). Click + icon for additional
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name	ber with Subgroup (1	2 digits). Click + icon for additional Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Subscriber First Name	ber with Subgroup (1	2 digits). Click + icon for additional Subscriber Last Name Subscriber Last Name
Enter Group Number Group Number (8 digits) OR Group Num Subscriber First Name Subscriber ID	ber with Subgroup (1	2 digits). Click + icon for additional Subscriber Last Name Subscriber Last Name







Submitting a Case



Submitting a Case



docx, .jpeg, .xls, .tiff	
	Printing a copy of
Print	request is available.



Submitting a Case

Once the case is submitted, you will be redirected to the Enrollment Inquiry & Support dashboard.

	bull winkle Account Settings Log Out
Excellus 🔄 🕅 Brokers	Q Search ? Get Help
Home Enroll & Update 🗸 Compare Plans 🗸 Billing Commissions & Reporting 🗸 Resources 🗸	
Brokers > Contact Us > Enrollment Inquiry & Support This is where you can locate the Case ID.	
Enrollment Inquiry & Support Your case has been submitted successfully. Your case ID is ENR-149001. If you have any questions regarding your case, please contact your ded Account Service Consultant. DASHBOARD If you have any questions regarding your case, please contact your dedicated Account Service Consultant. Create New Case My Cases	Clicking the refresh button at the top of the page will create duplicates. To see the updates in the Enrollment Inquiry & Support dashboard, click the "Search" button.
From To 03-16-2024 06-14-2024 C Search	



NOTES	
-------	--



