ENROLLMENT INQUIRY TRAINING GUIDE

Excellus BlueCross BlueShield

Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association

CONTENTS

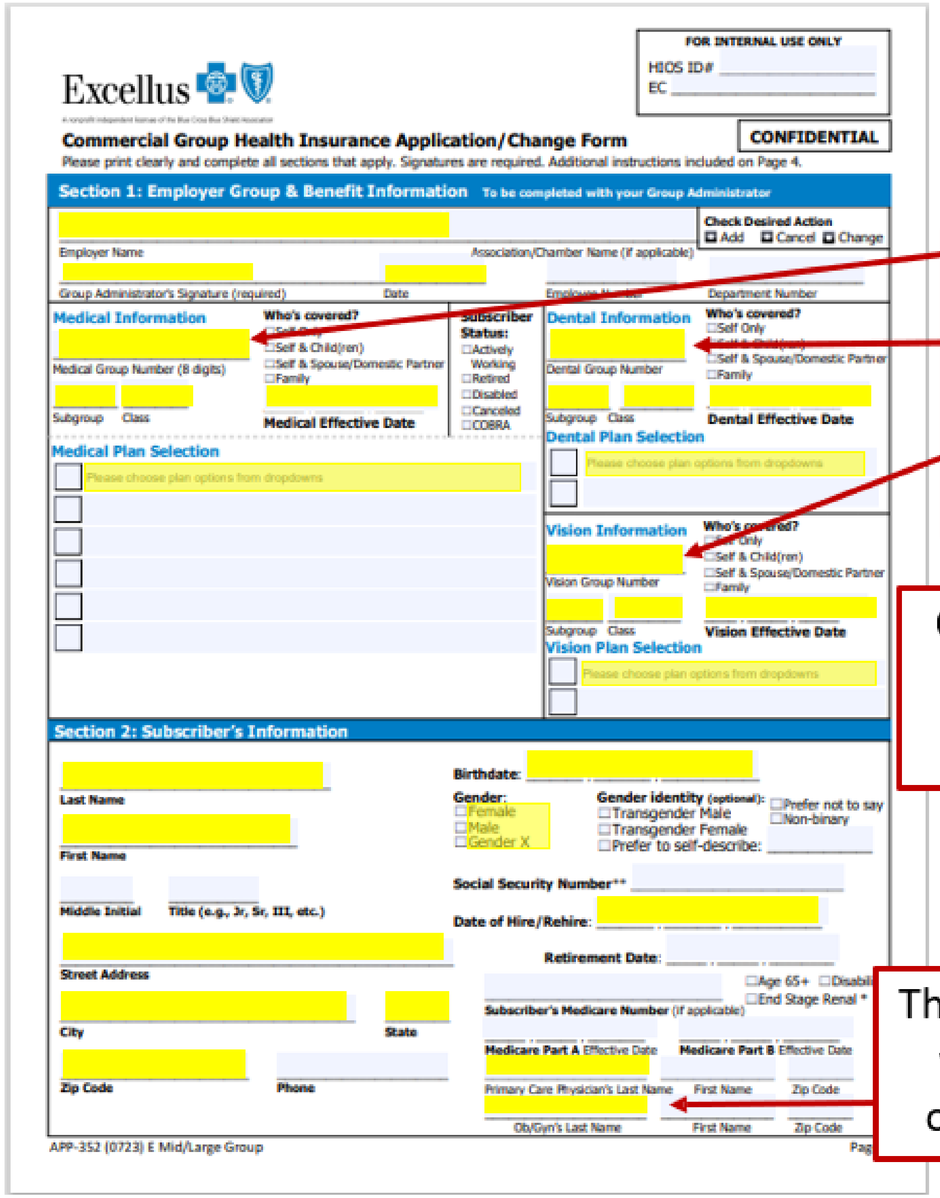
Overview of Forms

Process	Documentation Needed
New Add	Enrollment Application
Adding Dependent	Enrollment Application
QMCSO	Court order, QMCSO Certification Form, completed application if dependent is not already enrolled.
QMCSO Disenrollment	QMCSO Disenrollment Form, and court order
Custodial Parent	Court order, completed Enrollment Application if dependent is not already enrolled.
Disabled Dependent	Adult Disabled Dependent Form Application, if dependent is not already enrolled or becomes disabled prior to maximum age of contract.
Key Employee	Enrollment Application, letter on company letterhead. Letter must contain required information, refer to your Group Administrator's Guide under Enrollment and Maintenance procedures.

Process	Documentation Needed
Student Certification	Enrollment Application, Student Certification Form
Demographic Change	Enrollment Application or enter action needed in the Additional Details section of request
Cancel	• Enrollment Application or Membership Cancel Worksheet
Reinstate	• If within 30 days from cancellation date, okay to reinstate without a new application. Enter action needed in the Additional Details section of request • If over 30 days from the cancellation date, a new Enrollment Application is needed
Medicare	Medicare form or Enrollment Application
COBRA	Enrollment Application and COBRA Form is to be provided by either the employer group or Lifetime Benefit Solution (LBS) based on who is managing the COBRA benefit.

New Add Required Fields Enrollment Forms Overview

POS/HMO – Requires Primary Care Physician (PCP)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EC

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Check Desired Action ☐ Add ☐ Cancel ☐ Change

Employer Name | Association/Chamber Name (if applicable)

Group Administrator's Signature (required) | Date | Employee Number | Department Number

Medical Information | Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family

Medical Group Number (8 digits) | Subscriber Status: ☐Actively Working ☐Retired ☐Disabled ☐Canceled ☐COBRA

Subgroup | Class | Medical Effective Date

Medical Plan Selection

Please choose plan options from dropdowns

Dental Information | Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family

Dental Group Number | Subgroup | Class | Dental Effective Date

Dental Plan Selection

Please choose plan options from dropdowns

Vision Information | Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family

Vision Group Number | Subgroup | Class | Vision Effective Date

Vision Plan Selection

Please choose plan options from dropdowns

Section 2: Subscriber's Information

Last Name | First Name | Middle Initial | Title (e.g., Jr, Sr, III, etc.)

Street Address | City | State | Zip Code | Phone

Birthdate: | Gender: ☐Female ☐Male ☐Gender X | Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Prefer to self-describe: ☐Prefer not to say ☐Non-binary

Social Security Number** | Date of Hire/Rehire: | Retirement Date:

☐Age 65+ ☐Disabil ☐End Stage Renal *

Subscriber's Medicare Number (if applicable) | Medicare Part A Effective Date | Medicare Part B Effective Date

Primary Care Physician's Last Name | First Name | Zip Code

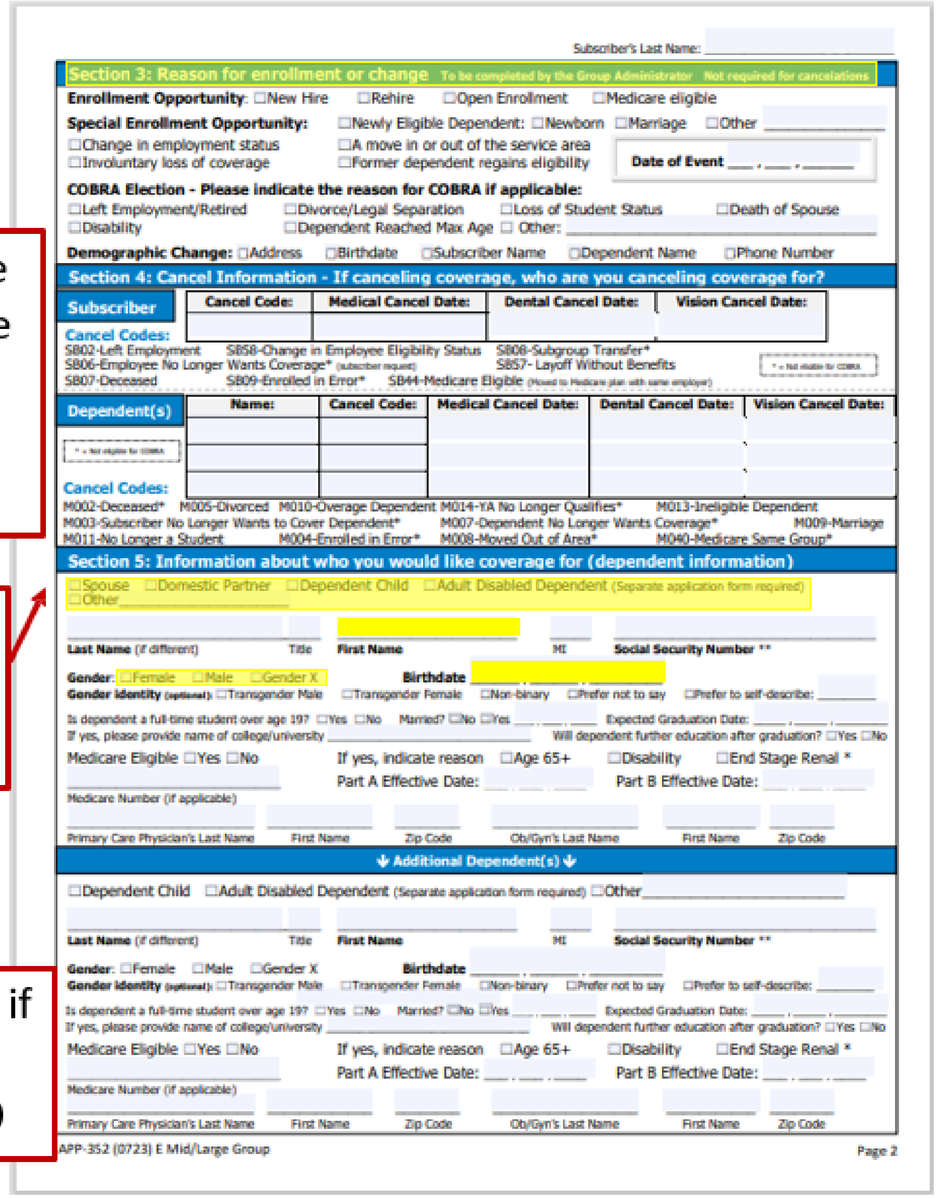
Ob/Gyn's Last Name | First Name | Zip Code

APP-352 (0723) E Mid/Large Group | Pag

Only fill out the product you are enrolling into (Medical, Dental, Vision)

Only required if you are adding dependents

This is needed only if you are a female over the age of 19


Subscriber's Last Name:

Section 3: Reason for enrollment or change To be completed by the Group Administrator Not required for cancelations

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other

☐Change in employment status ☐Involuntary loss of coverage ☐A move in or out of the service area ☐Former dependent regains eligibility

Date of Event

COBRA Election - Please indicate the reason for COBRA if applicable:

☐Left Employment/Retired ☐Disability ☐Divorce/Legal Separation ☐Dependent Reached Max Age ☐Loss of Student Status ☐Other: ☐Death of Spouse

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

Cancel Codes:
SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits
SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)
* = Not eligible for COBRA

Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:

* = Not eligible for COBRA

Cancel Codes:
M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other

Last Name (if different) | Title | First Name | MI | Social Security Number **

Gender: ☐Female ☐Male ☐Gender X | Birthdate

Gender identity (optional): ☐Transgender Male ☐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 ☐Yes Expected Graduation Date:

If yes, please provide name of college/university Will dependent further education after graduation? ☐Yes ☐No

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

Part A Effective Date: | Part B Effective Date:

Medicare Number (if applicable)

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip Code

Additional Dependent(s)

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other

Last Name (if different) | Title | First Name | MI | Social Security Number **

Gender: ☐Female ☐Male ☐Gender X | Birthdate

Gender identity (optional): ☐Transgender Male ☐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 ☐Yes Expected Graduation Date:

If yes, please provide name of college/university Will dependent further education after graduation? ☐Yes ☐No

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

Part A Effective Date: | Part B Effective Date:

Medicare Number (if applicable)

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip Code

APP-352 (0723) E Mid/Large Group | Page 2

Subscriber's Last Name: _____

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

Last Name (if different) | Title | First Name | MI | Social Security Number **

Gender: ☐Female ☐Male ☐Gender X Birthdate _____

Gender identity (optional): ☐Transgender Male ☐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 ☐Yes _____ Expected Graduation Date: _____

If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐

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

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

Primary Care Physician's Last Name | First Name | Zip Code | Ob/Gyn's Last Name | First Name | Zip 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? ☐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? _____

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

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who 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 Provider (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 Provider (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 such violation.

Subscriber Signature _____ **Date** _____

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

Only complete if other coverage is applicable.

Instructions for completing the Group Health Insurance Application/Change Form

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.

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 **optional gender identity section** 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.

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 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:

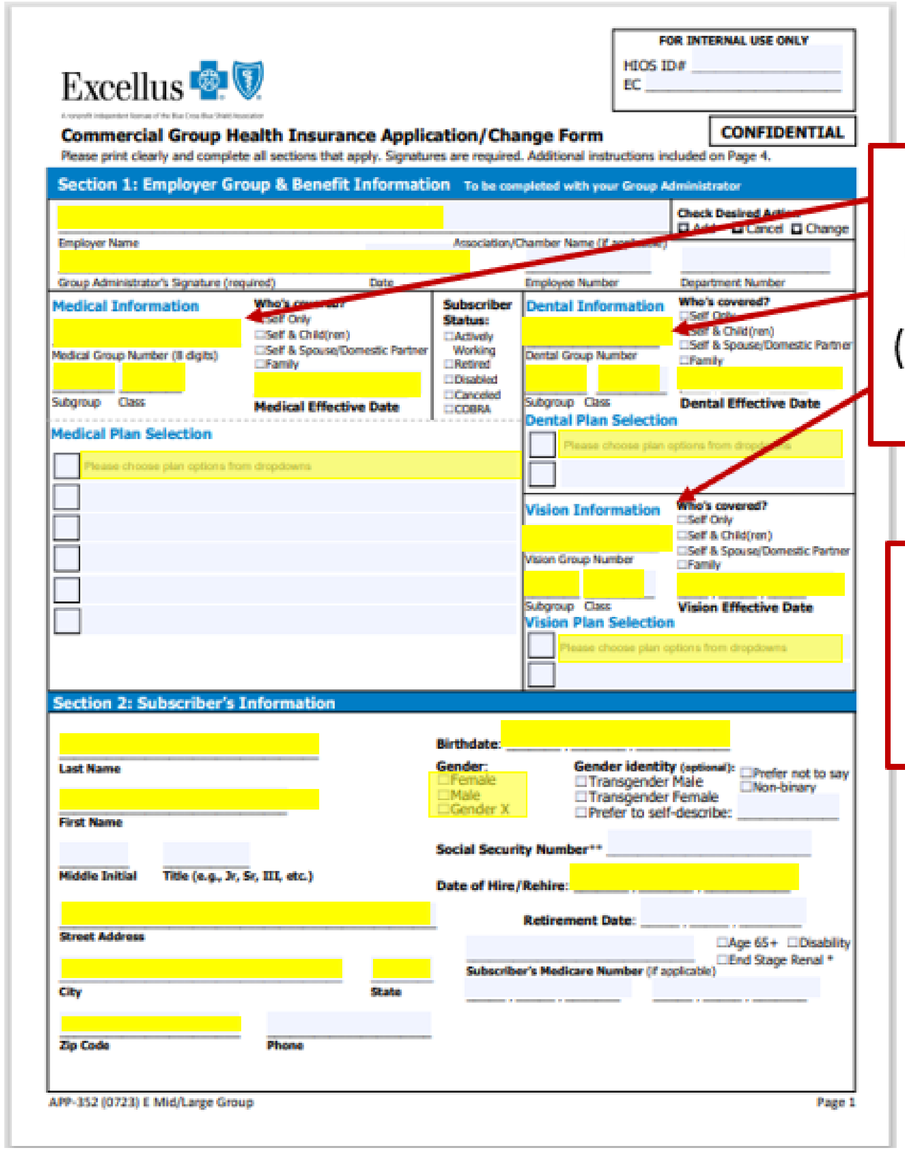
- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group 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.

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.

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



Excellus

FOR INTERNAL USE ONLY
HIOS ID# _____
EC _____

Commercial Group Health Insurance Application/Change Form — CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Check Desired Action: ☐ Add ☐ Cancel ☐ Change

Employer Name | Association/Chamber Name (If applicable) | Group Administrator's Signature (required) | Date | Employee Number | Department Number

Medical Information
Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family
Medical Group Number (8 digits) | Subgroup | Class | Medical Effective Date
Subscriber Status: ☐Actively Working ☐Retired ☐Disabled ☐Canceled ☐COBRA
Medical Plan Selection Please choose plan options from dropdowns

Dental Information
Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family
Dental Group Number | Subgroup | Class | Dental Effective Date
Dental Plan Selection Please choose plan options from dropdowns

Vision Information
Who's covered? ☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family
Vision Group Number | Subgroup | Class | Vision Effective Date
Vision Plan Selection Please choose plan options from dropdowns

Section 2: Subscriber's Information

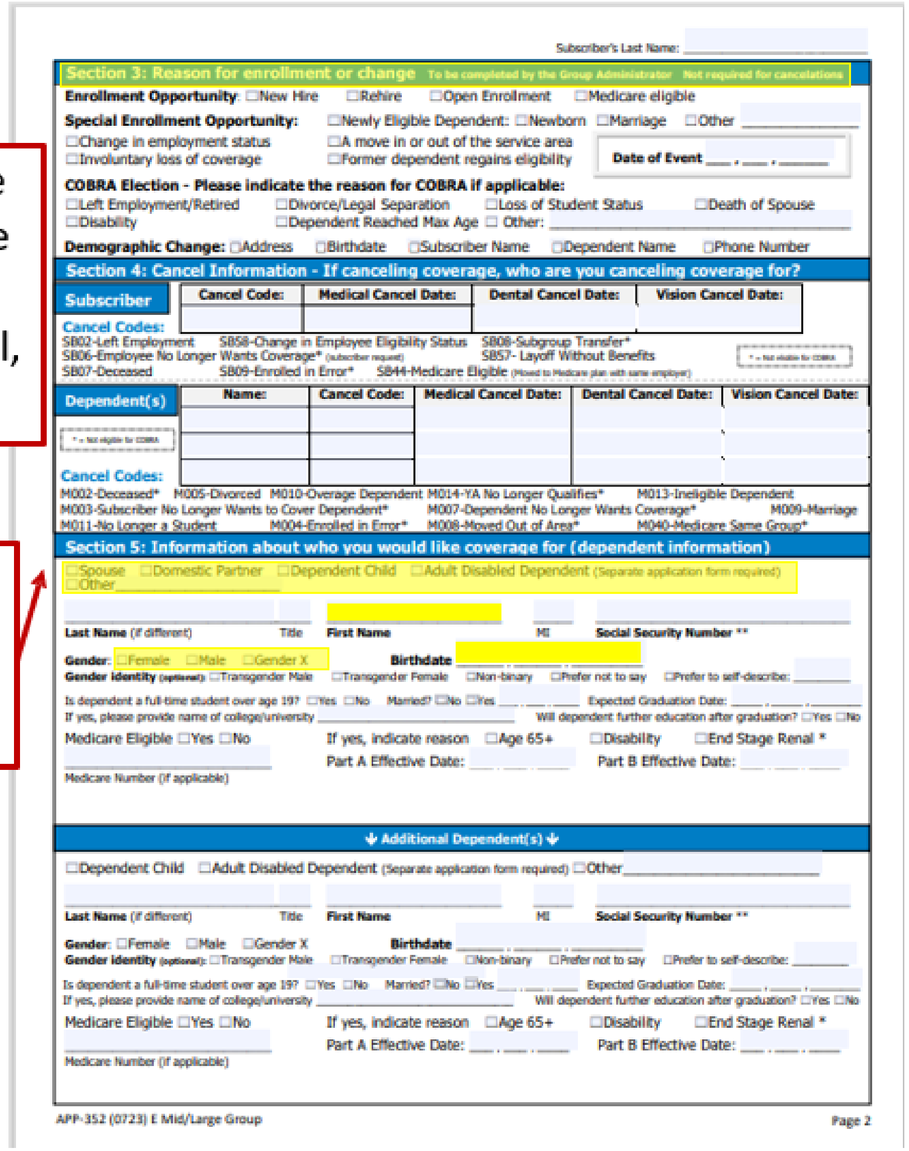
Last Name | First Name | Middle Initial | Title (e.g., Jr, Sr, III, etc.) | Street Address | City | State | Zip Code | Phone

Birthdate: | Gender: ☐Female ☐Male ☐Gender X | Gender identity (optional): ☐Transgender Male ☐Transgender Female ☐Prefer to self-describe: ☐Prefer not to say ☐Non-binary | Social Security Number** | Date of Hire/Rehire: | Retirement Date: | ☐Age 65+ ☐Disability ☐End Stage Renal * | Subscriber's Medicare Number (if applicable)

APP-352 (0723) E Mid/Large Group — Page 1

Only fill out the product you are enrolling into (Medical, Dental, Vision)

Only required if you are adding dependents



Subscriber's Last Name: _____

Section 3: Reason for enrollment or change To be completed by the Group Administrator Not required for cancelations

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____
☐Change in employment status ☐A move in or out of the service area
☐Involuntary loss of coverage ☐Former dependent regains eligibility
Date of Event ___ / ___ / ____

COBRA Election - Please indicate the reason for COBRA if applicable:
☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
Subscriber				

Cancel Codes:
SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
SB06-Employee No Longer Wants Coverage* (subscriber request) SB57- Layoff Without Benefits
SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)
* = Not eligible for COBRA

Dependent(s)	Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	Vision Cancel Date:
* = Not eligible for COBRA					

Cancel Codes:
M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

Last Name (if different) | Title | First Name | MI | Social Security Number **
Gender: ☐Female ☐Male ☐Gender X | Birthdate
Gender identity (optional): ☐Transgender Male ☐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 ☐Yes ___ ___ ____ Expected Graduation Date: ___ / ___ / ____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No
Medicare Eligible ☐Yes ☐No | If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *
Medicare Number (if applicable) | Part A Effective Date: ___ ___ ____ | Part B Effective Date: ___ ___ ____

Additional Dependent(s)

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

Last Name (if different) | Title | First Name | MI | Social Security Number **
Gender: ☐Female ☐Male ☐Gender X | Birthdate
Gender identity (optional): ☐Transgender Male ☐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 ☐Yes ___ ___ ____ Expected Graduation Date: ___ / ___ / ____
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐No
Medicare Eligible ☐Yes ☐No | If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *
Medicare Number (if applicable) | Part A Effective Date: ___ ___ ____ | Part B Effective Date: ___ ___ ____

APP-352 (0723) E Mid/Large Group — Page 2

Subscriber's Last Name: _____

☐Dependent Child ☐Adult Disabled Dependent (Separate application form required) ☐Other_____

Last Name (if different) | Title | **First Name** | MI | **Social Security Number** **

Gender: ☐Female ☐Male ☐Gender X **Birthdate**
Gender identity (optional): ☐Transgender Male ☐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 ☐Yes Expected Graduation Date:
If yes, please provide name of college/university _____ Will dependent further education after graduation? ☐Yes ☐

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *
Part A Effective Date: Part B Effective Date:
Medicare Number (if applicable)

Note: Use an additional application 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? ☐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? _____
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

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who 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 Provider (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 Provider (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 such violation.

Subscriber Signature _____ **Date** _____

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

Only complete if other coverage is applicable.

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information
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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 **optional gender identity section** 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.

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.

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Qualified guidelines for coverage include:

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- 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.

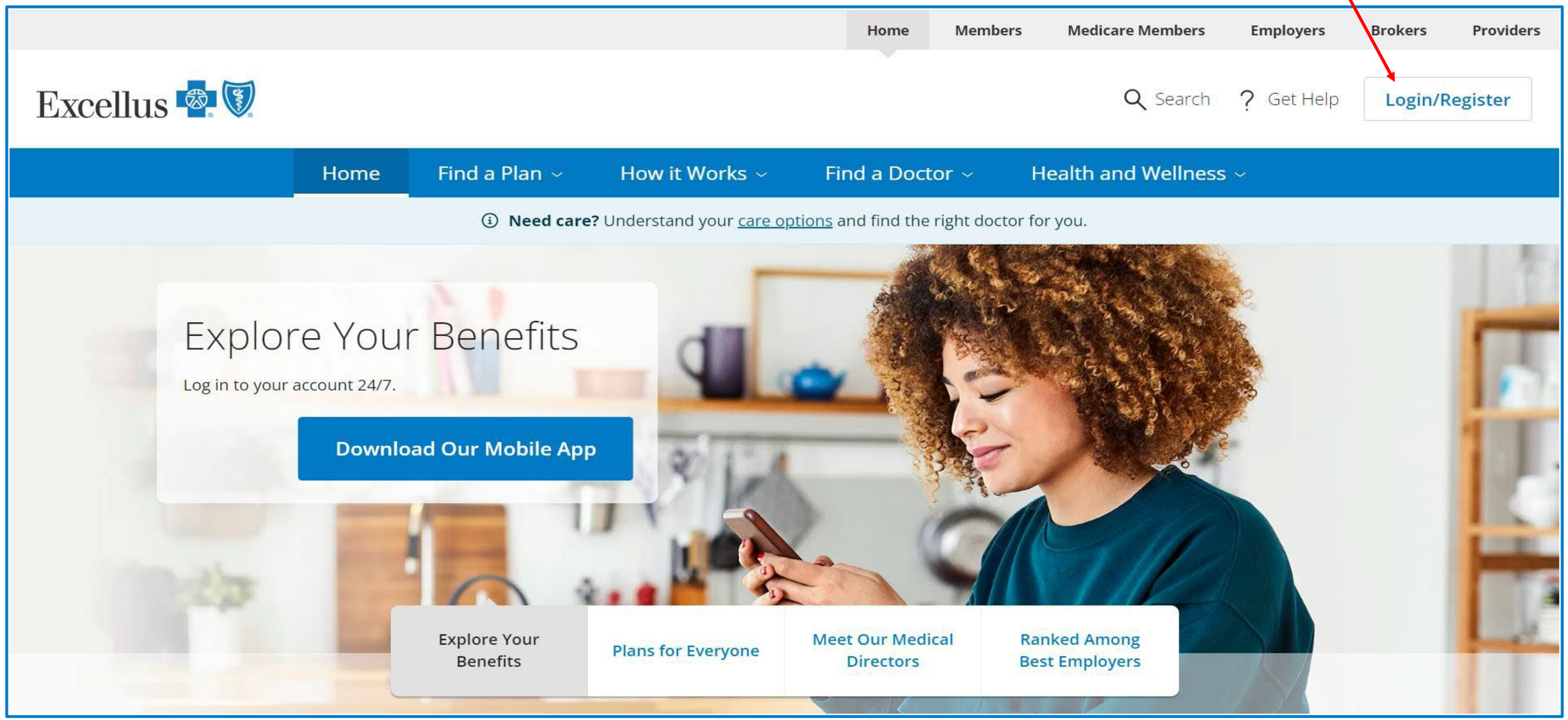
Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

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.

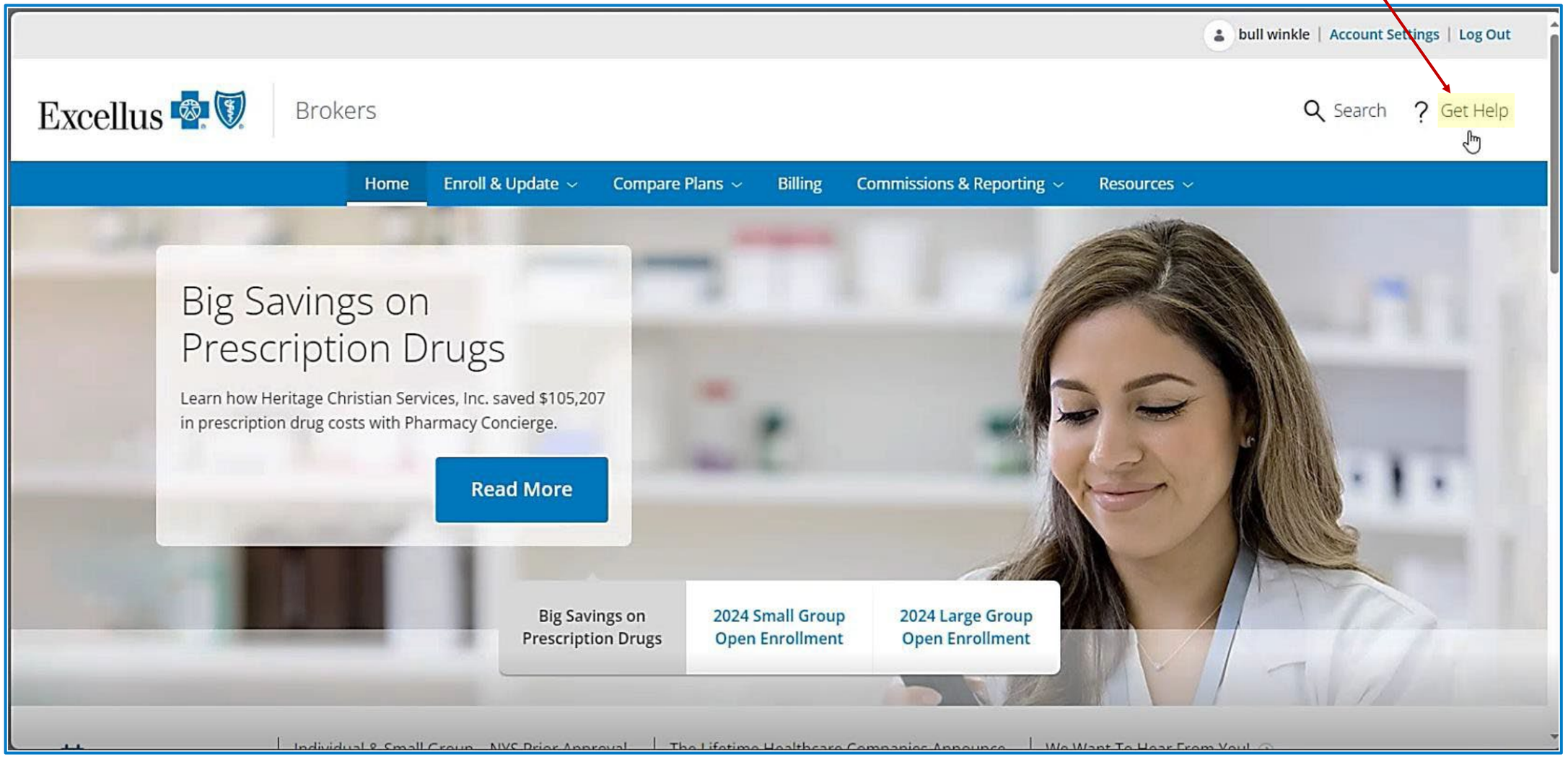
How to Access the Enrollment Inquiry & Support Dashboard

Visit www.excellusbcbs.com

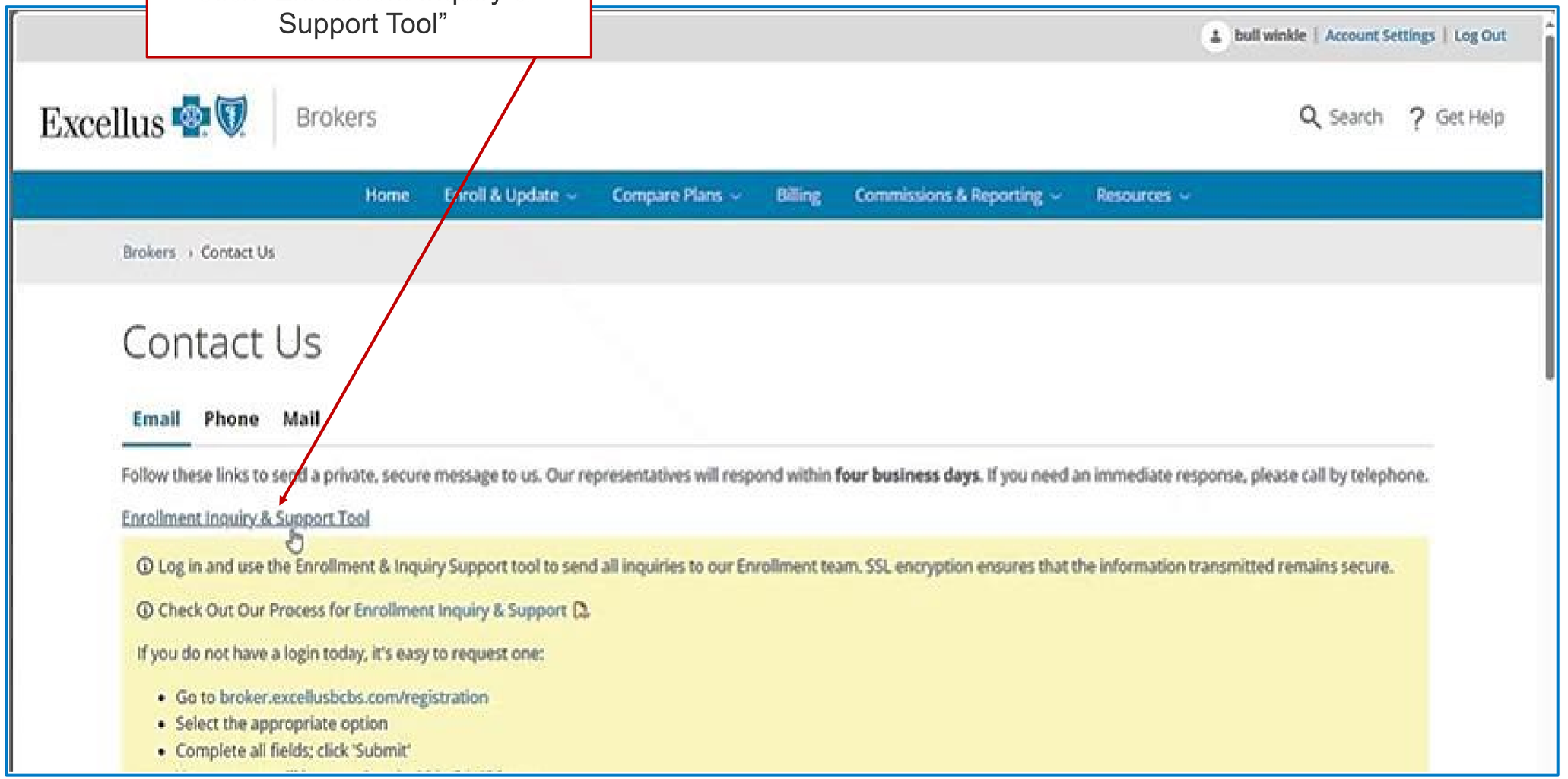
Click “Login/Register”



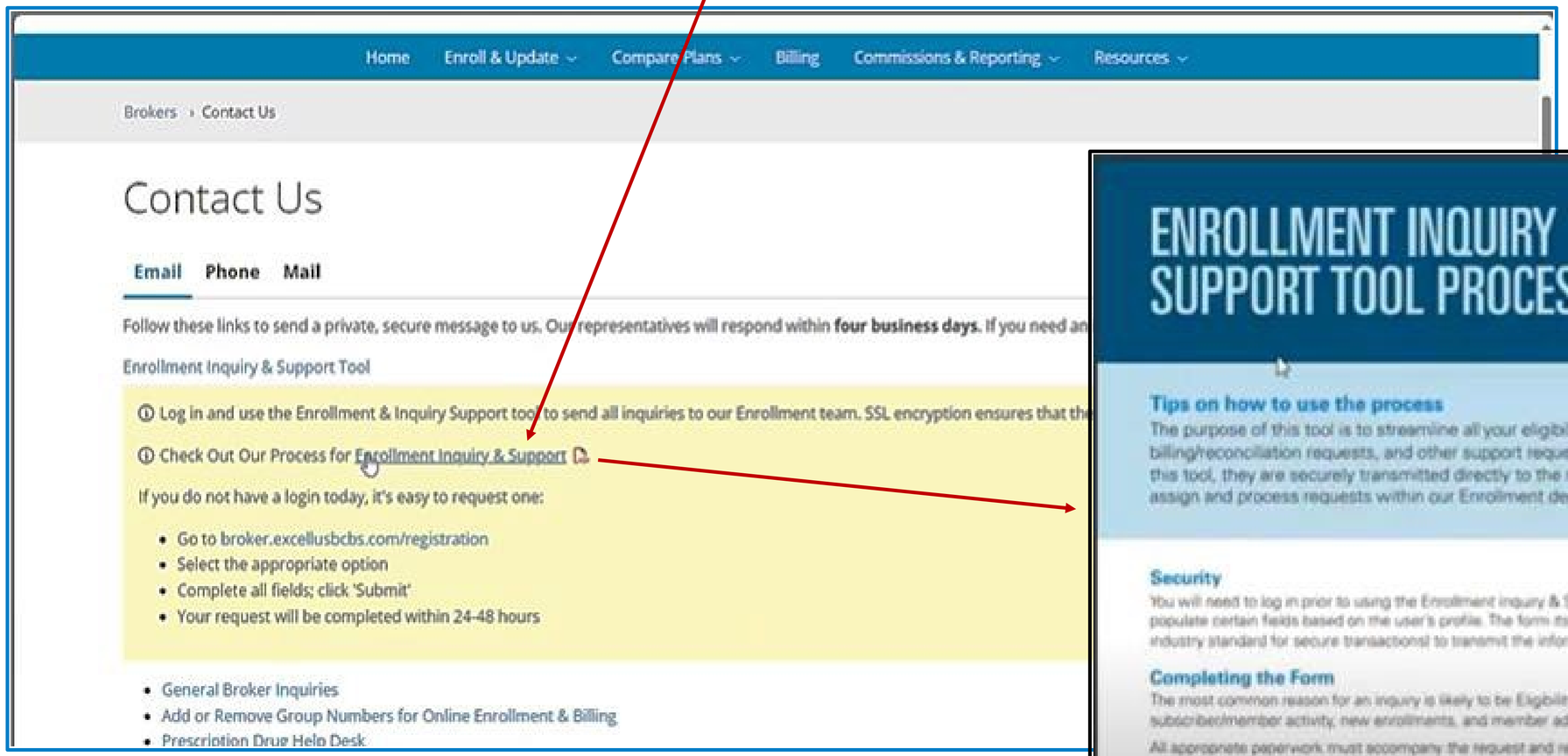
Click “Get Help” in the top right-hand corner



Click “Enrollment Inquiry & Support Tool”

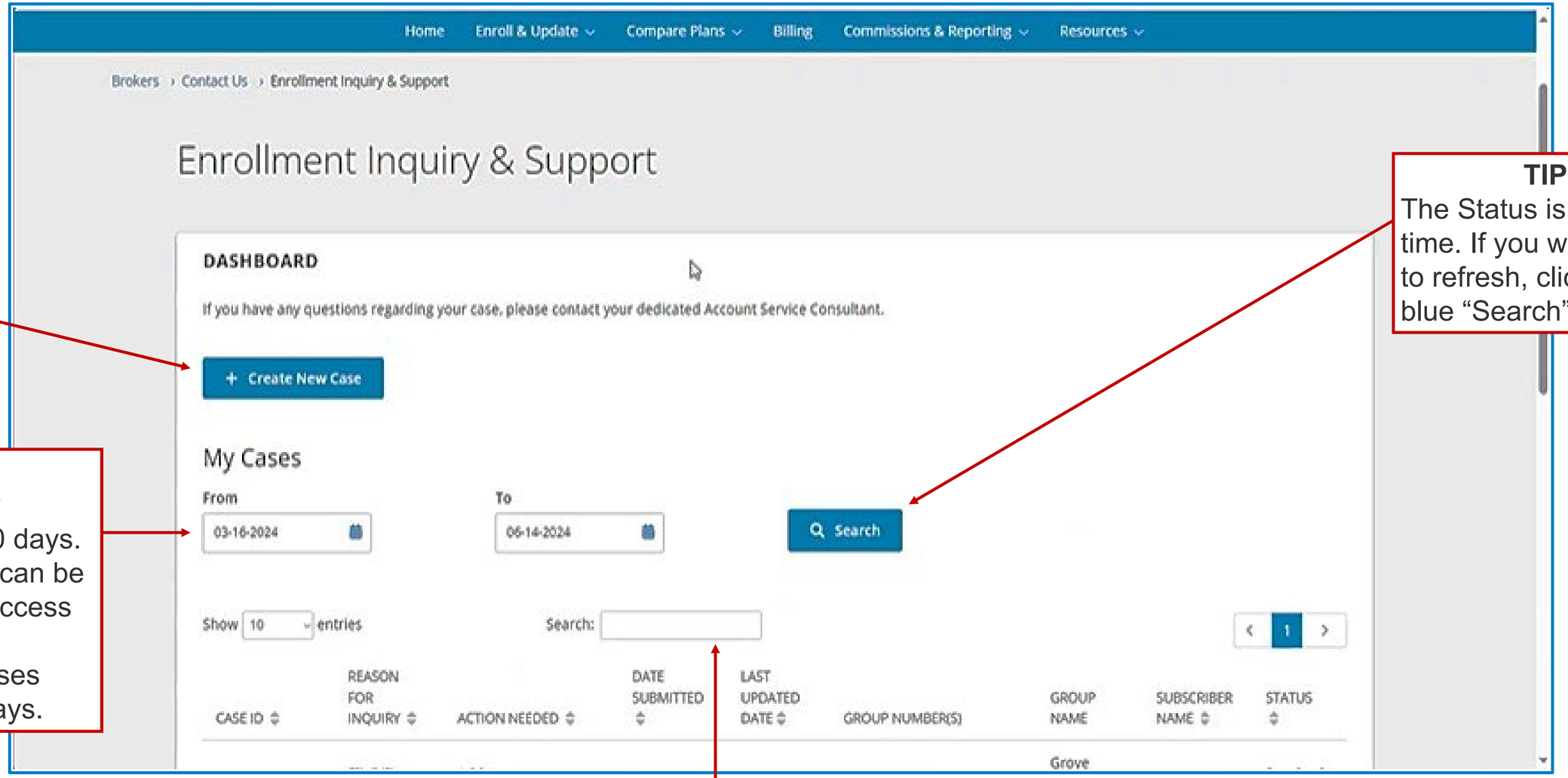


To access a tip, click “Enrollment Inquiry & Support



Creating a New Case

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



To Create a New Case

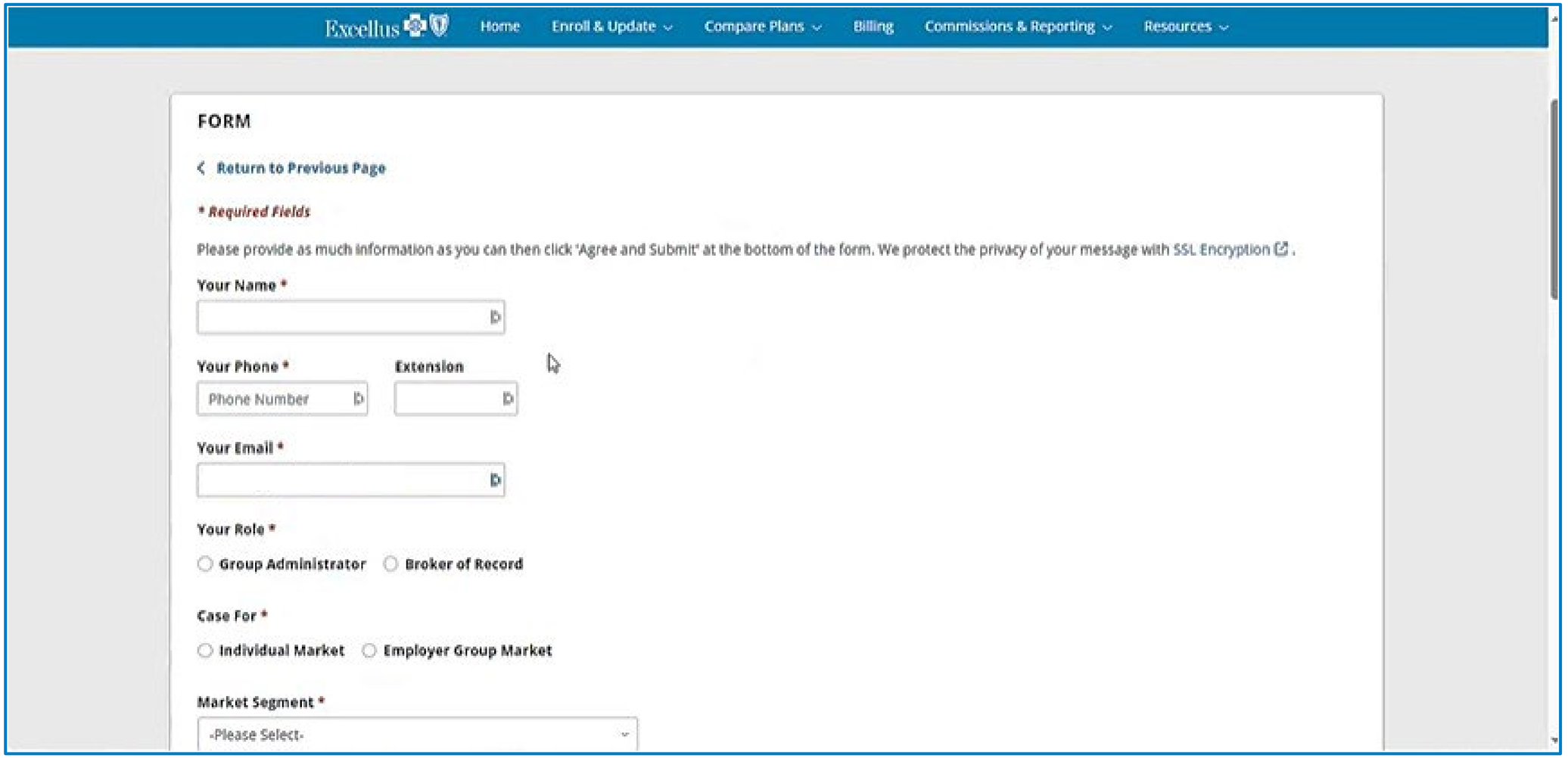
The system automatically defaults to 90 days. These dates can be changed to access previously submitted cases beyond 90 days.

TIP:
The Status is in real time. If you would like to refresh, click the blue “Search” button.

Use the Search bar to enter keywords.

Excellus

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 (*).



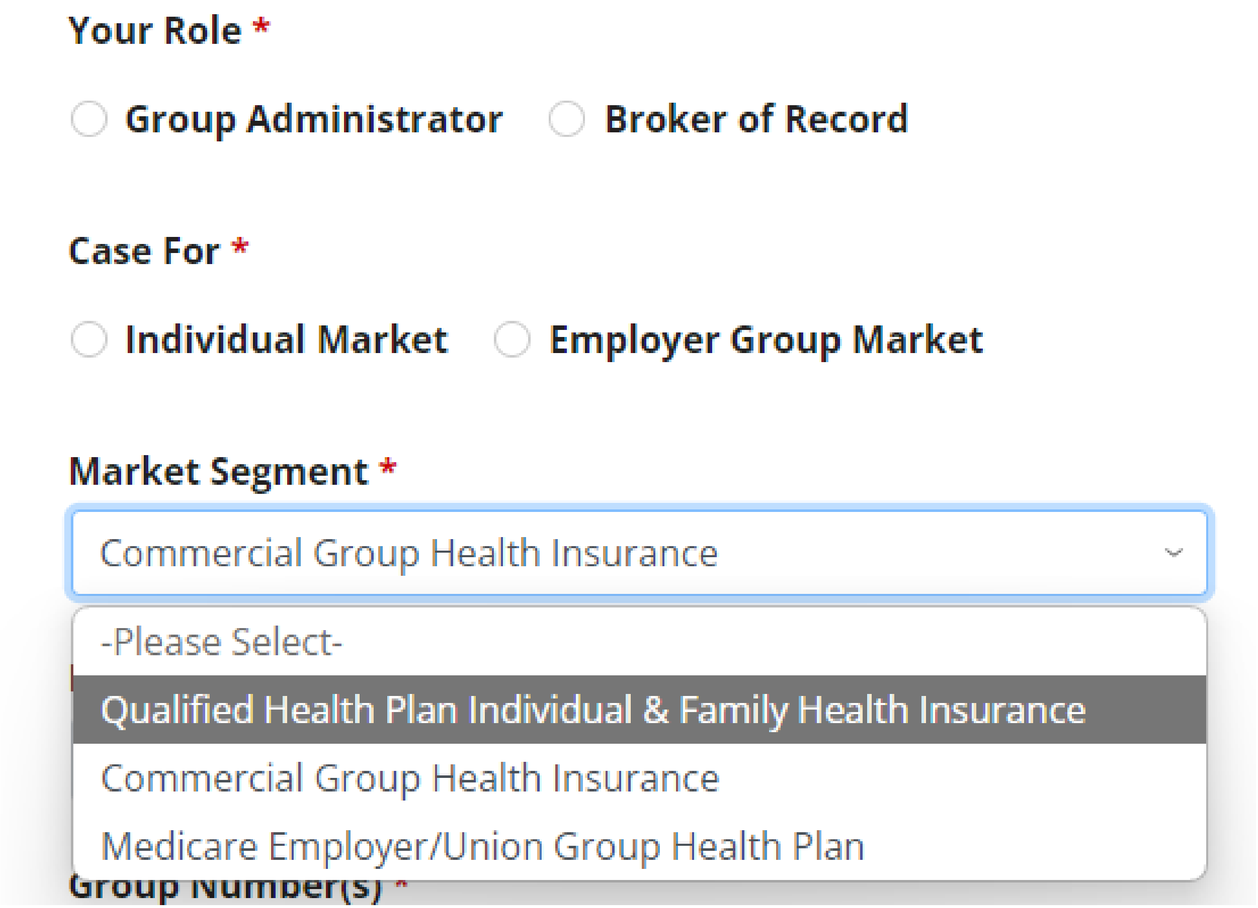
Case For: Employer Group Market

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

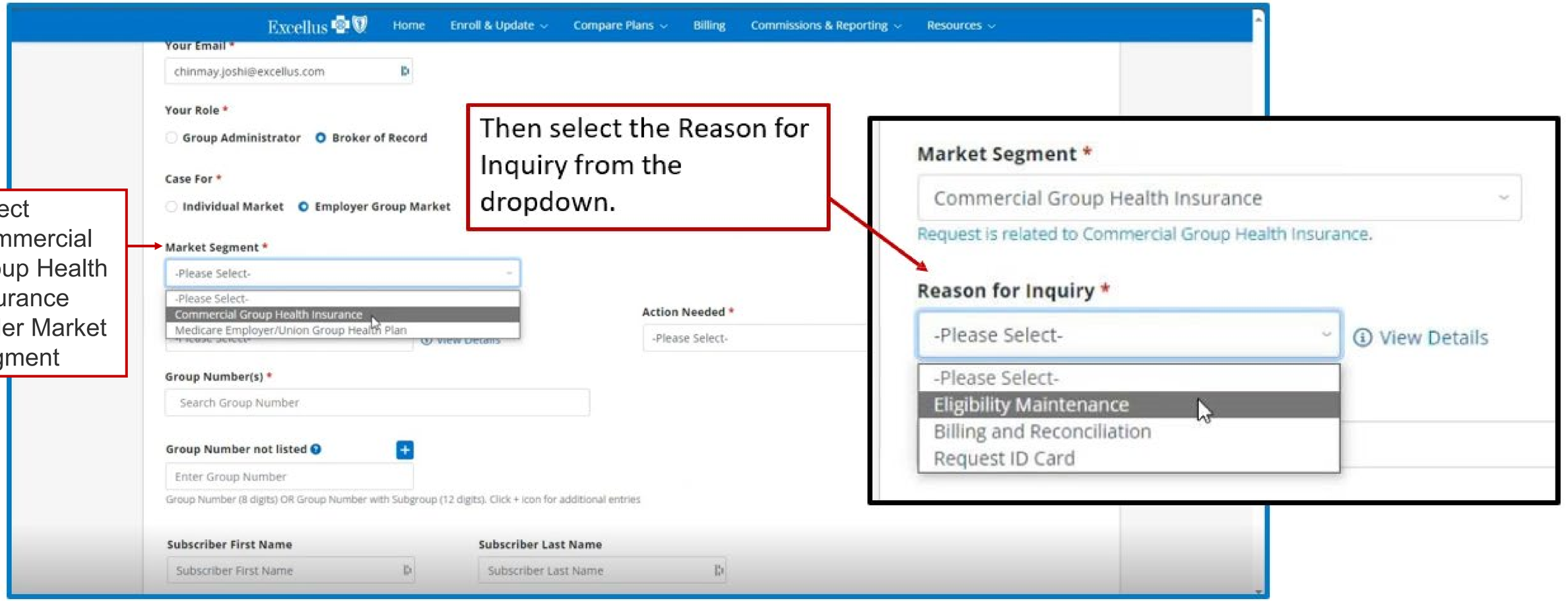
In the Case For field select Employer Group Market.

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



Market Segment:
Commercial Group Health Insurance

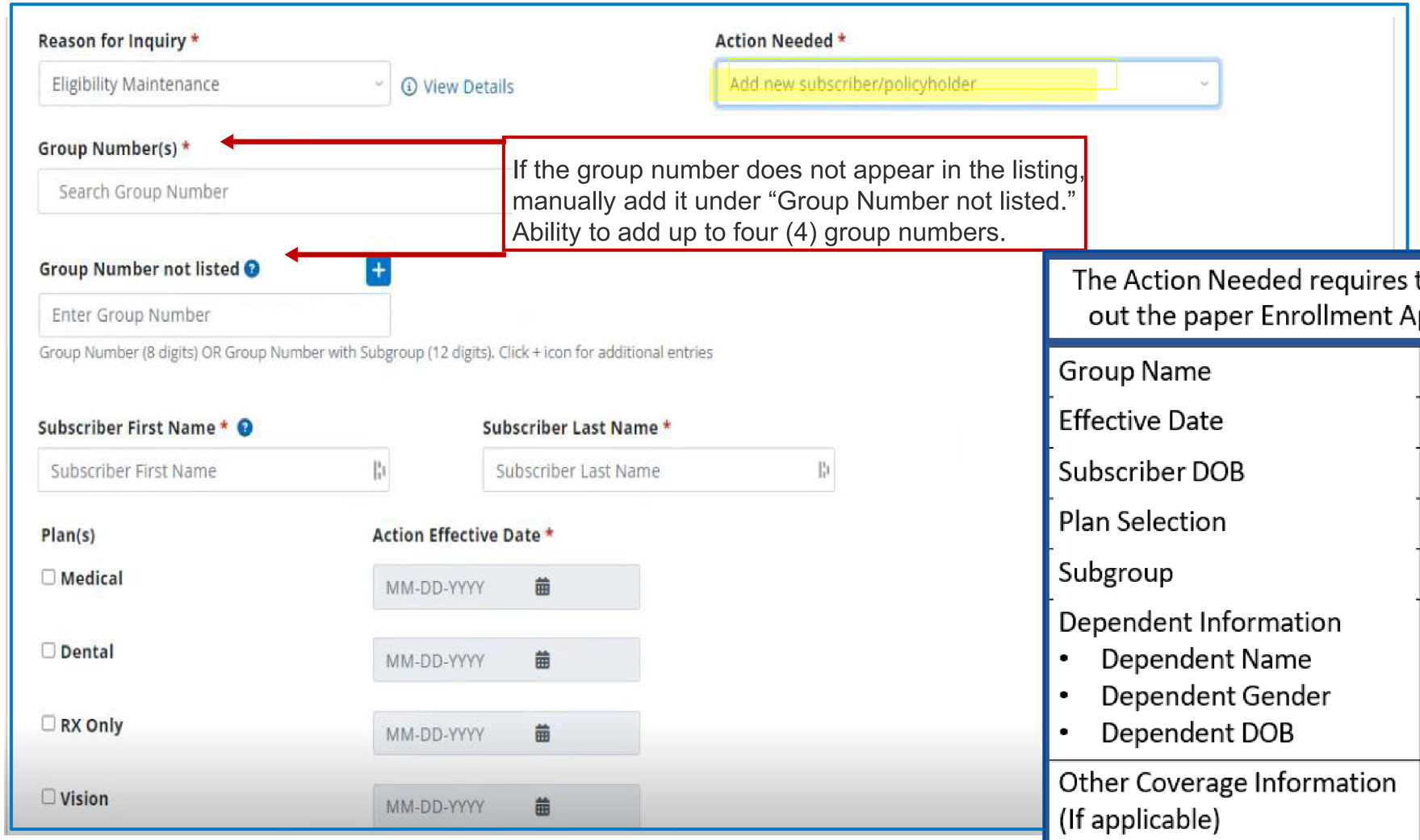


Commercial Group Health Insurance

Reason for Inquiry:

Eligibility Maintenance

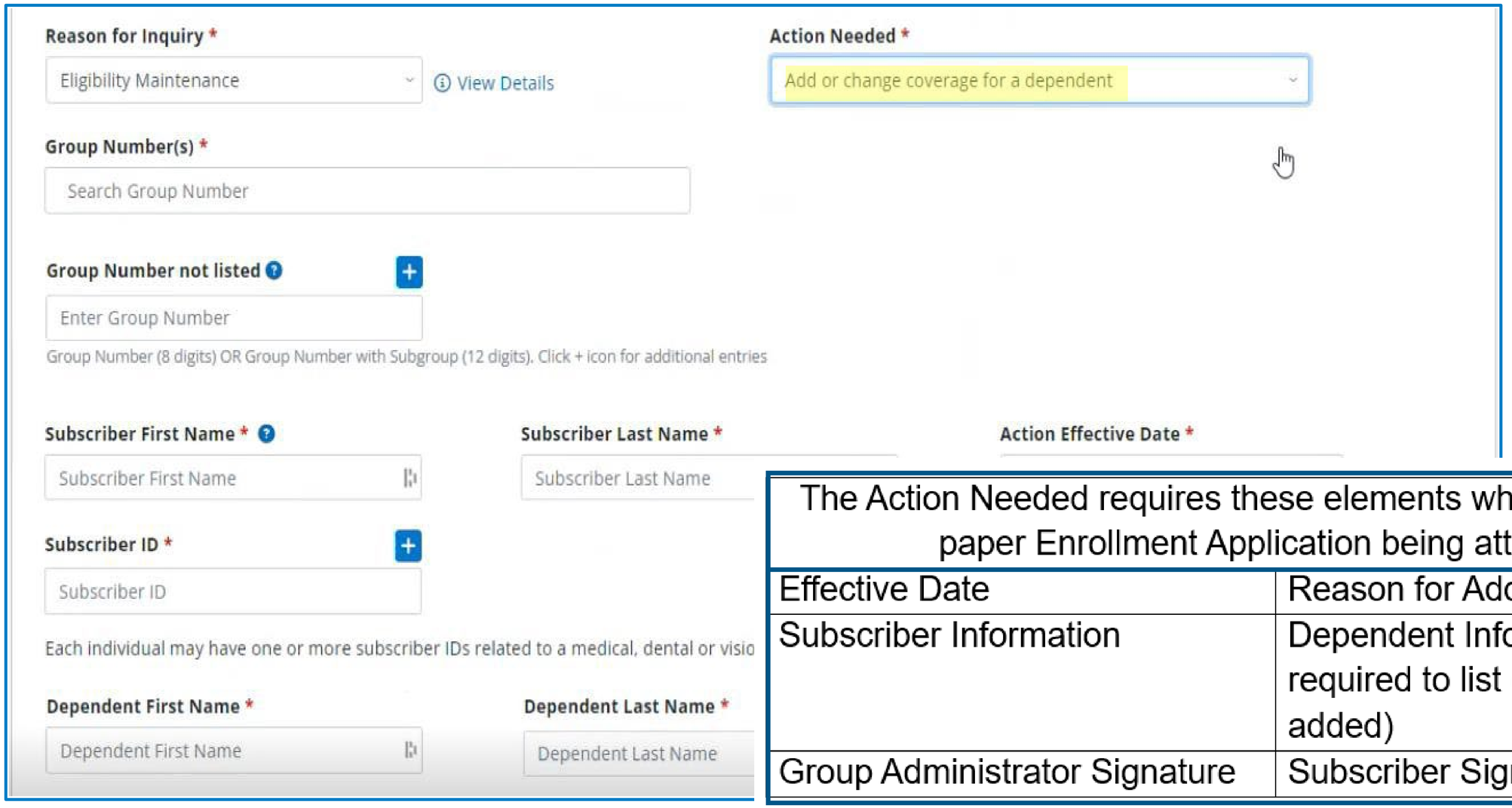
Action Needed: Add new subscriber/policyholder



If the group number does not appear in the listing, manually add it under “Group Number not listed.” Ability to add up to four (4) group numbers.

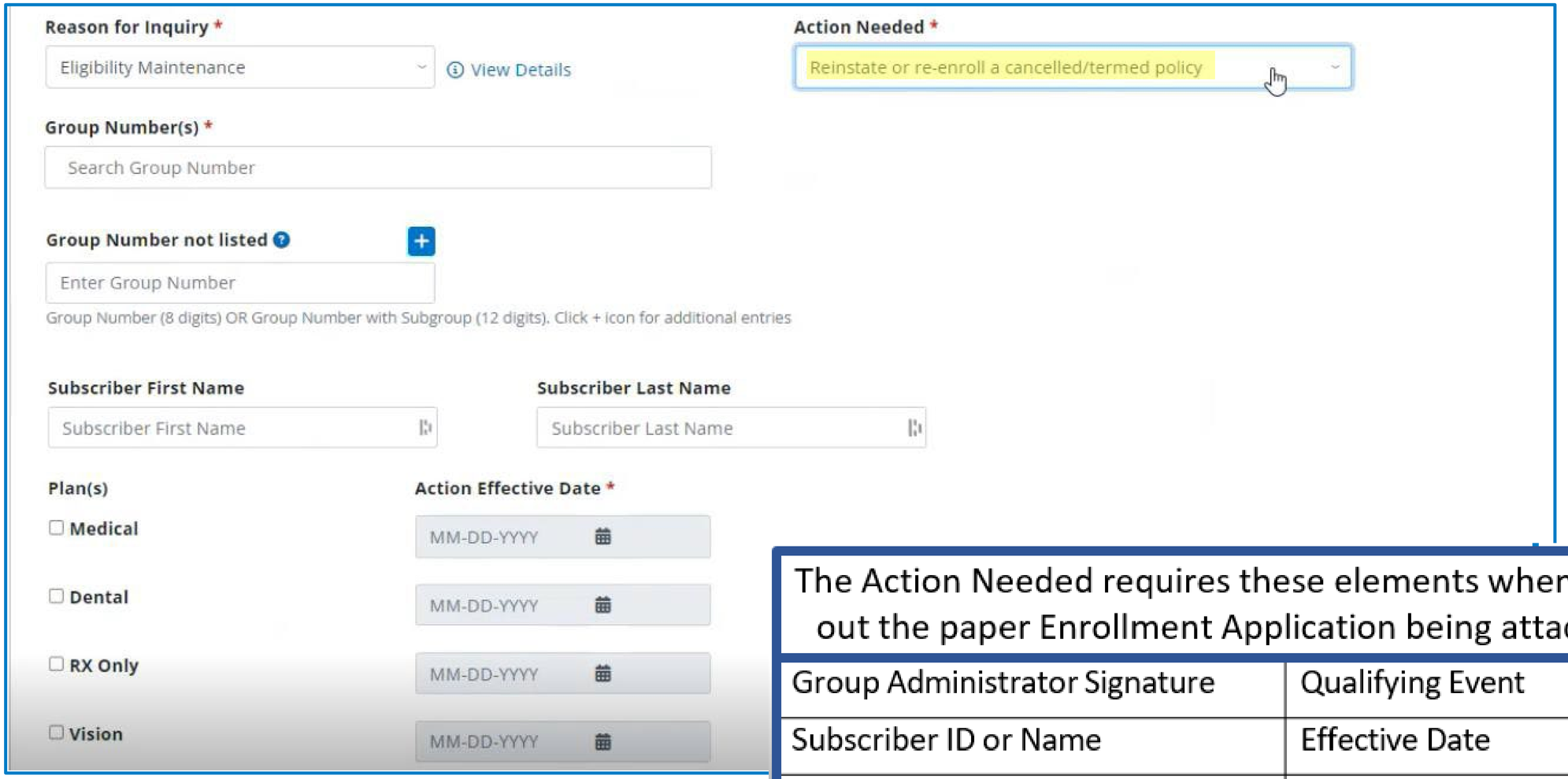
The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Group Name	Group Number
Effective Date	Subscriber Name
Subscriber DOB	Subscriber Gender
Plan Selection	Class
Subgroup	Qualifying Event
Dependent Information • Dependent Name • Dependent Gender • Dependent DOB	Relationship
Other Coverage Information (If applicable)	Group Administrator Signature
Subscriber Signature	

Action Needed: Add or change coverage for a dependent



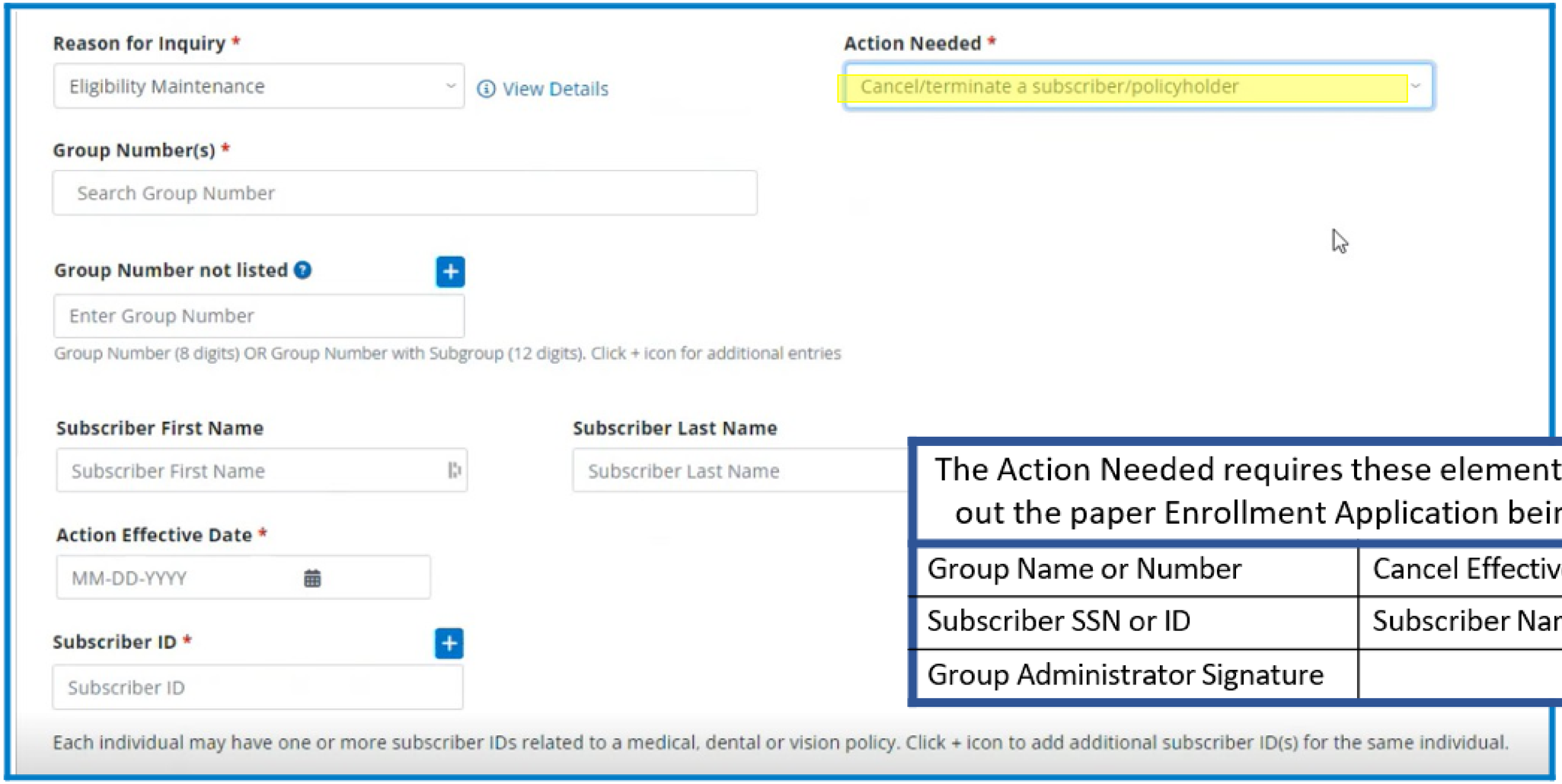
The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Effective Date	Reason for Adding
Subscriber Information	Dependent Information (only required to list dependent being added)
Group Administrator Signature	Subscriber Signature

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



The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Group Administrator Signature	Qualifying Event
Subscriber ID or Name	Effective Date
Group Name	Group Number

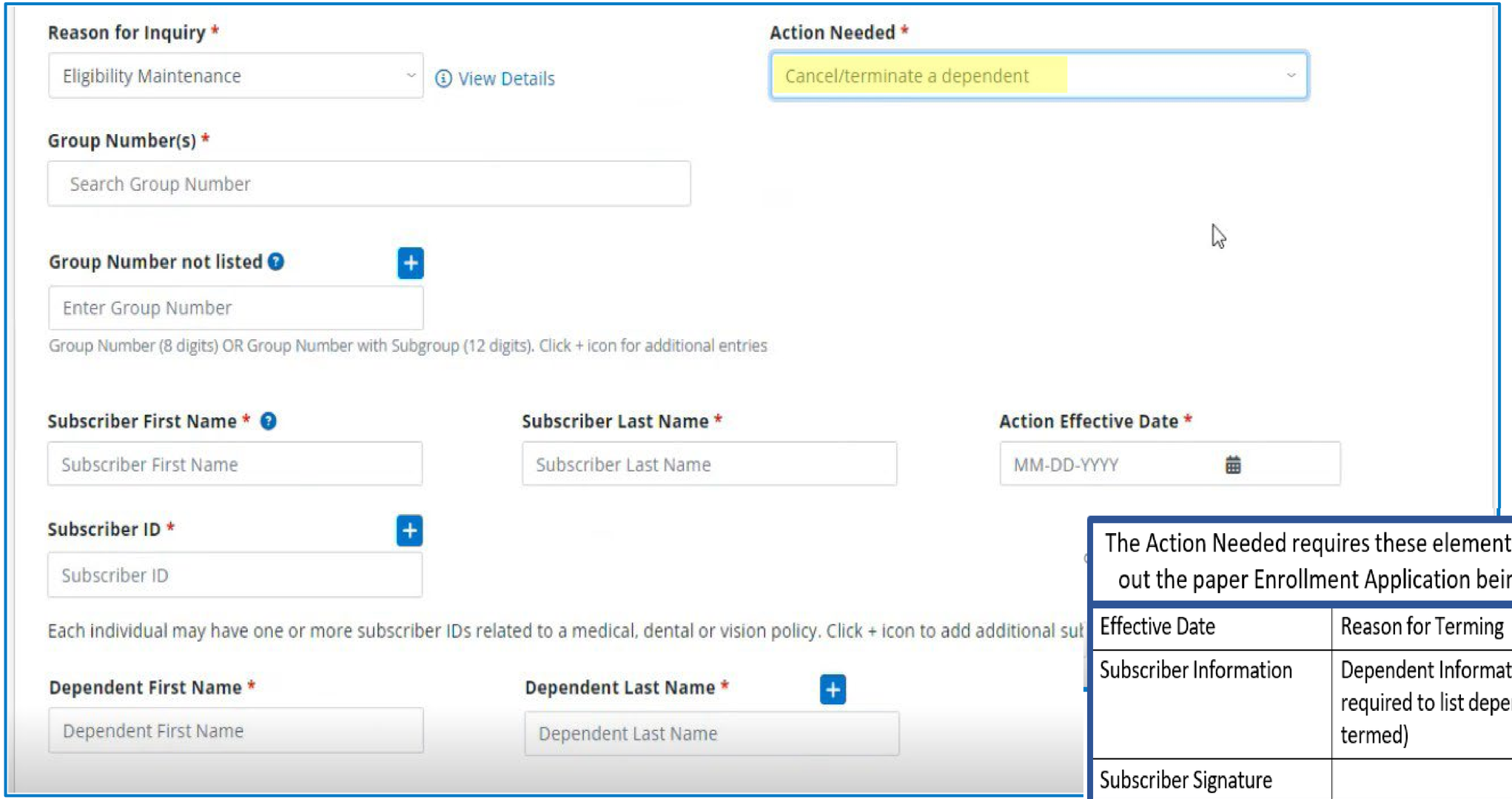
Action Needed: Cancel/terminate a subscriber/policyholder



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

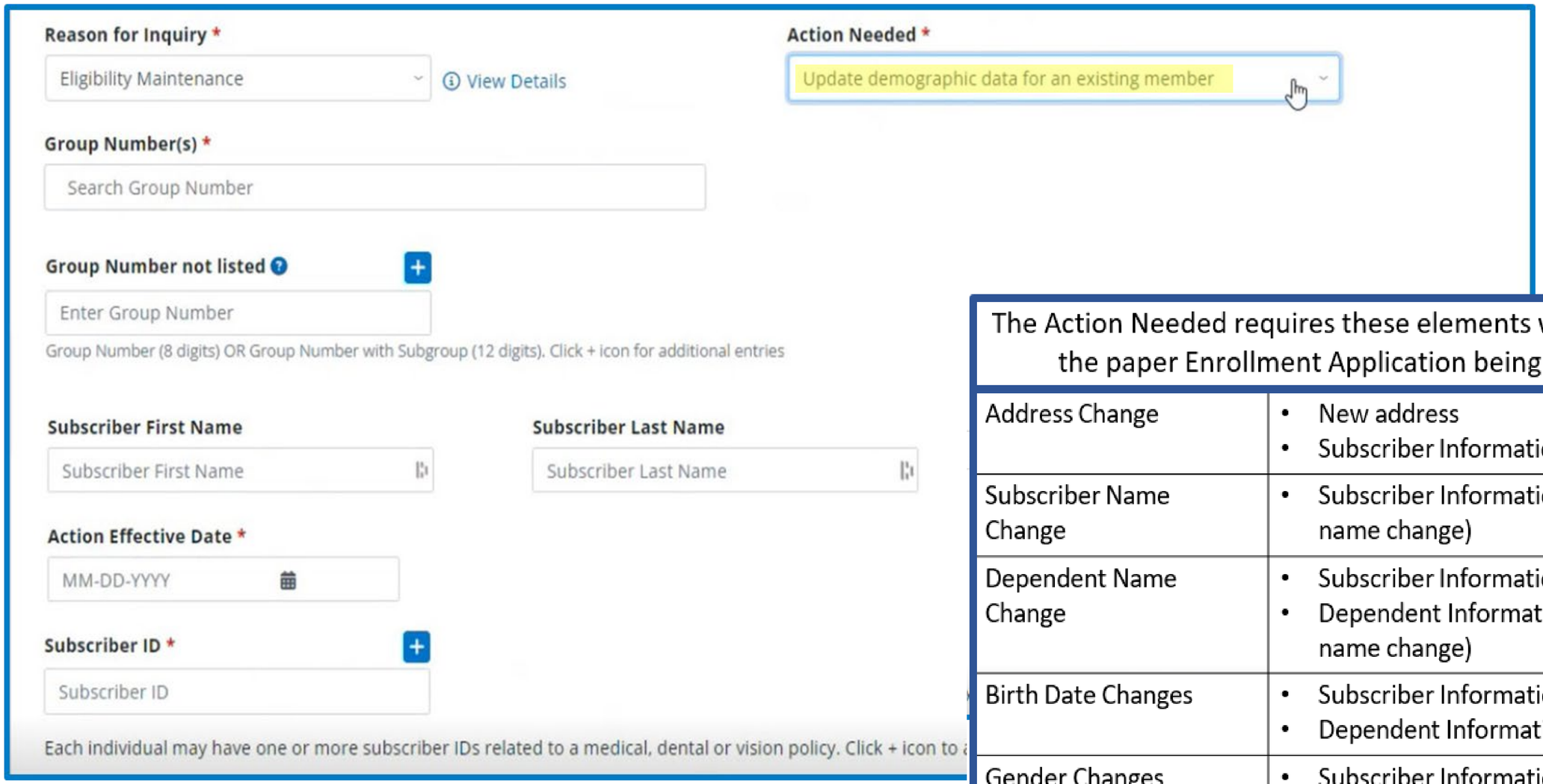
Group Name or Number	Cancel Effective Date
Subscriber SSN or ID	Subscriber Name
Group Administrator Signature	

Action Needed: Cancel/terminate a dependent



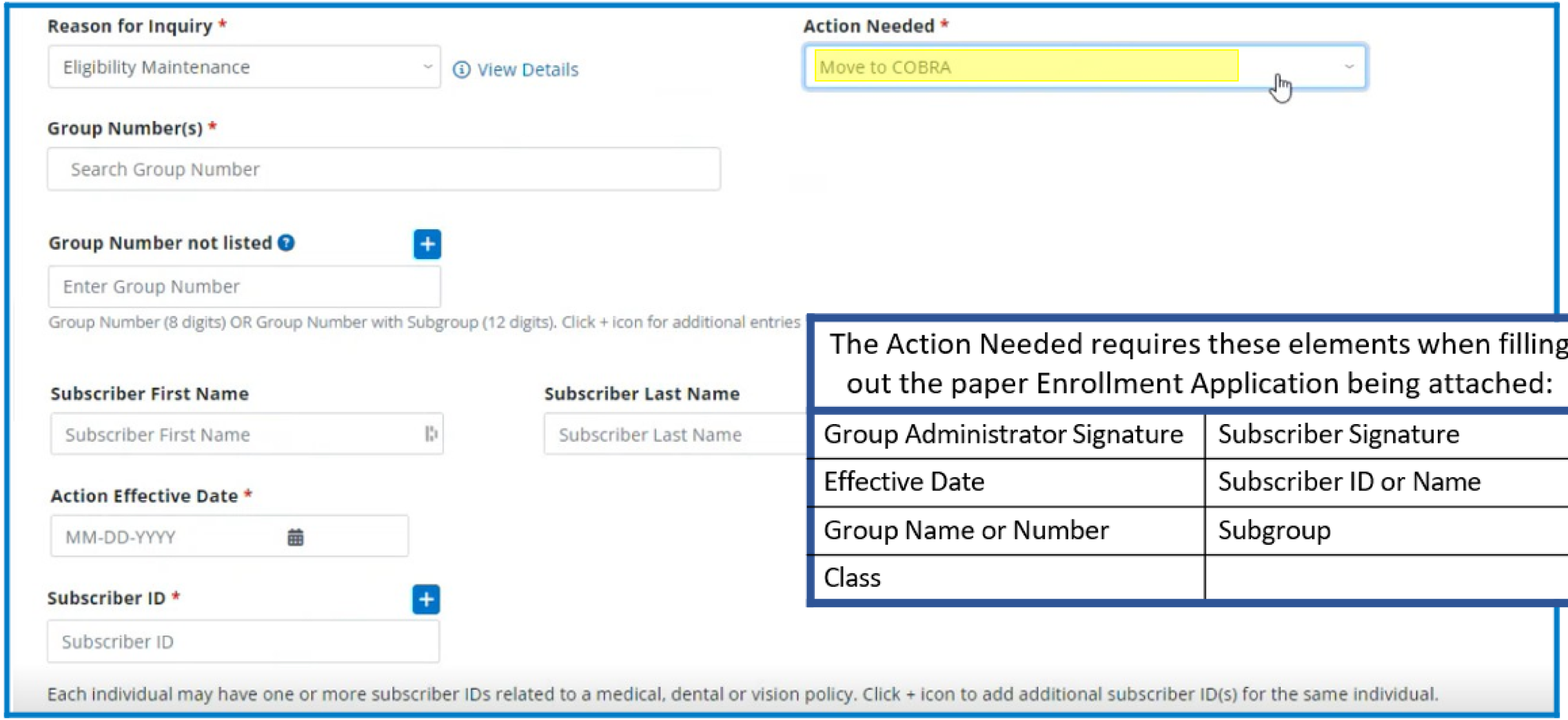
The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Effective Date	Reason for Terming
Subscriber Information	Dependent Information (only required to list dependent being termed)
Subscriber Signature	

Action Needed: Update demographic data for an existing member



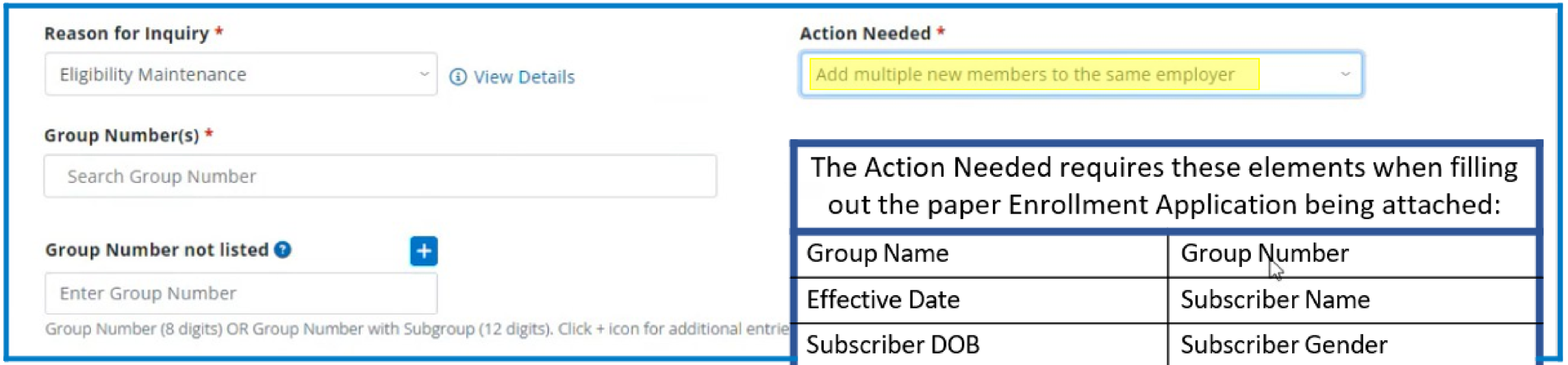
The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Address Change	• New address • Subscriber Information
Subscriber Name Change	• Subscriber Information (including name change)
Dependent Name Change	• Subscriber Information • Dependent Information (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: Move to COBRA



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	Subgroup
Class	

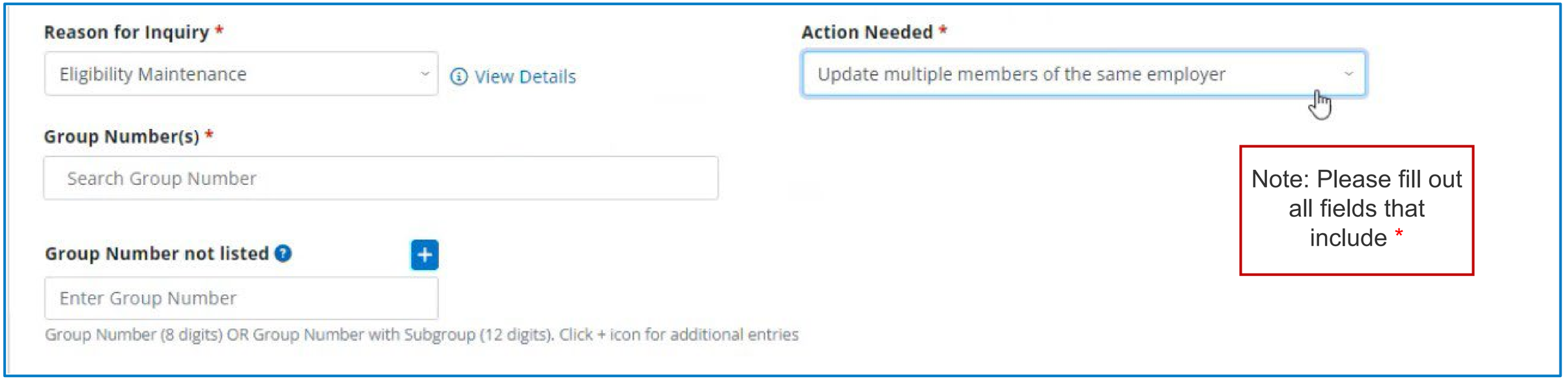
Action Needed: Add multiple new members to the same employer



Application needed for each member being added to the same employer group.

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	Other Coverage Information (If applicable)
Relationship	Group Administrator Signature
Subscriber Signature	

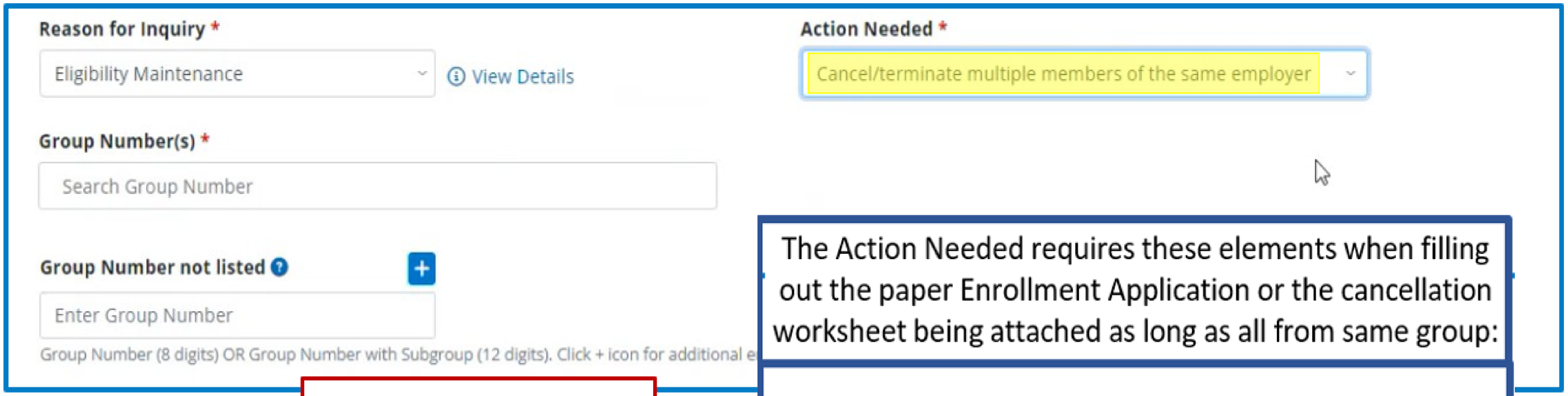
Action Needed: Update multiple members of the same employer



Note: Please fill out all fields that include *

Required fields depend on what needs to be updated

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

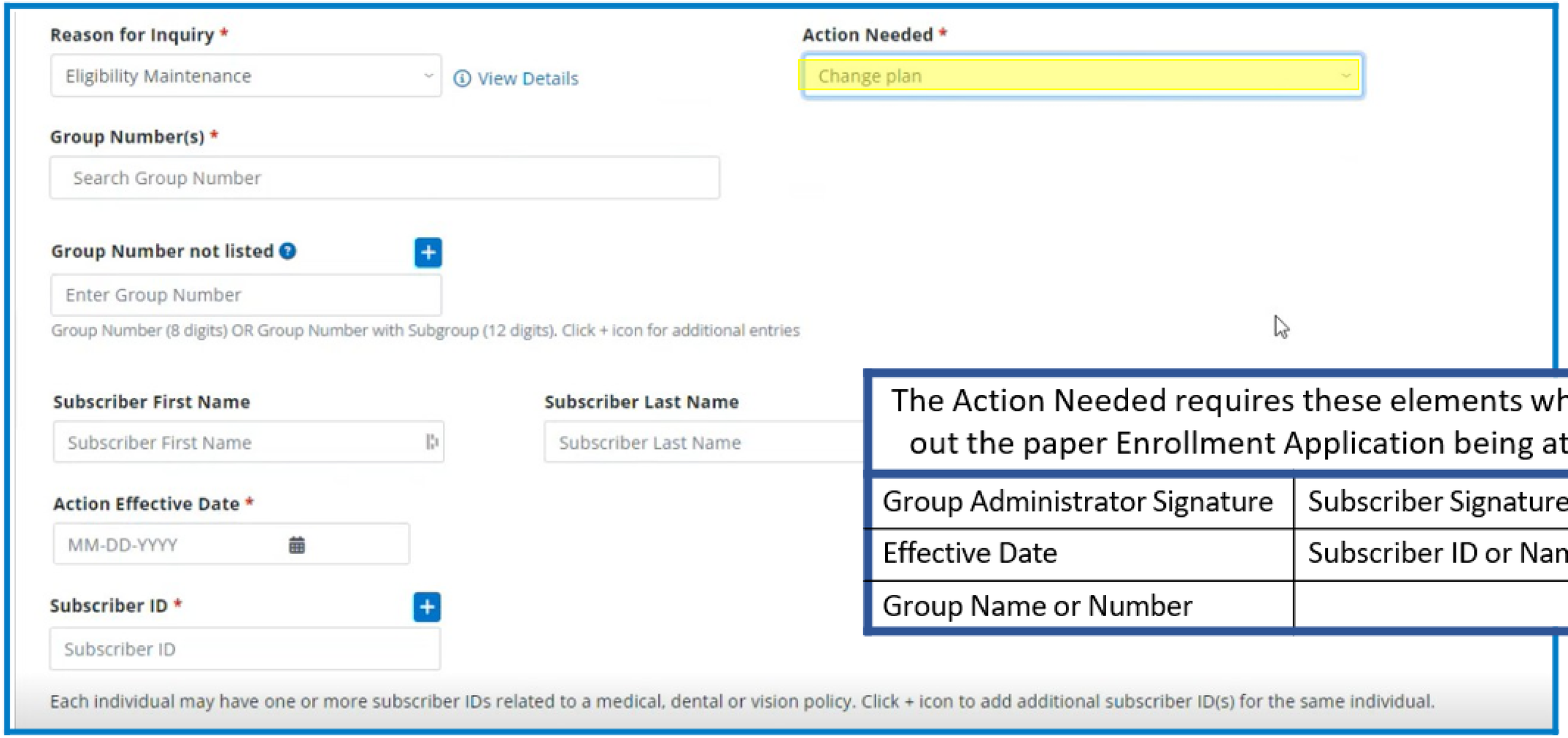


For each member being canceled from the same employer group

The Action Needed requires these elements when filling out the paper Enrollment Application or the cancellation worksheet being attached as long as all from same group:

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

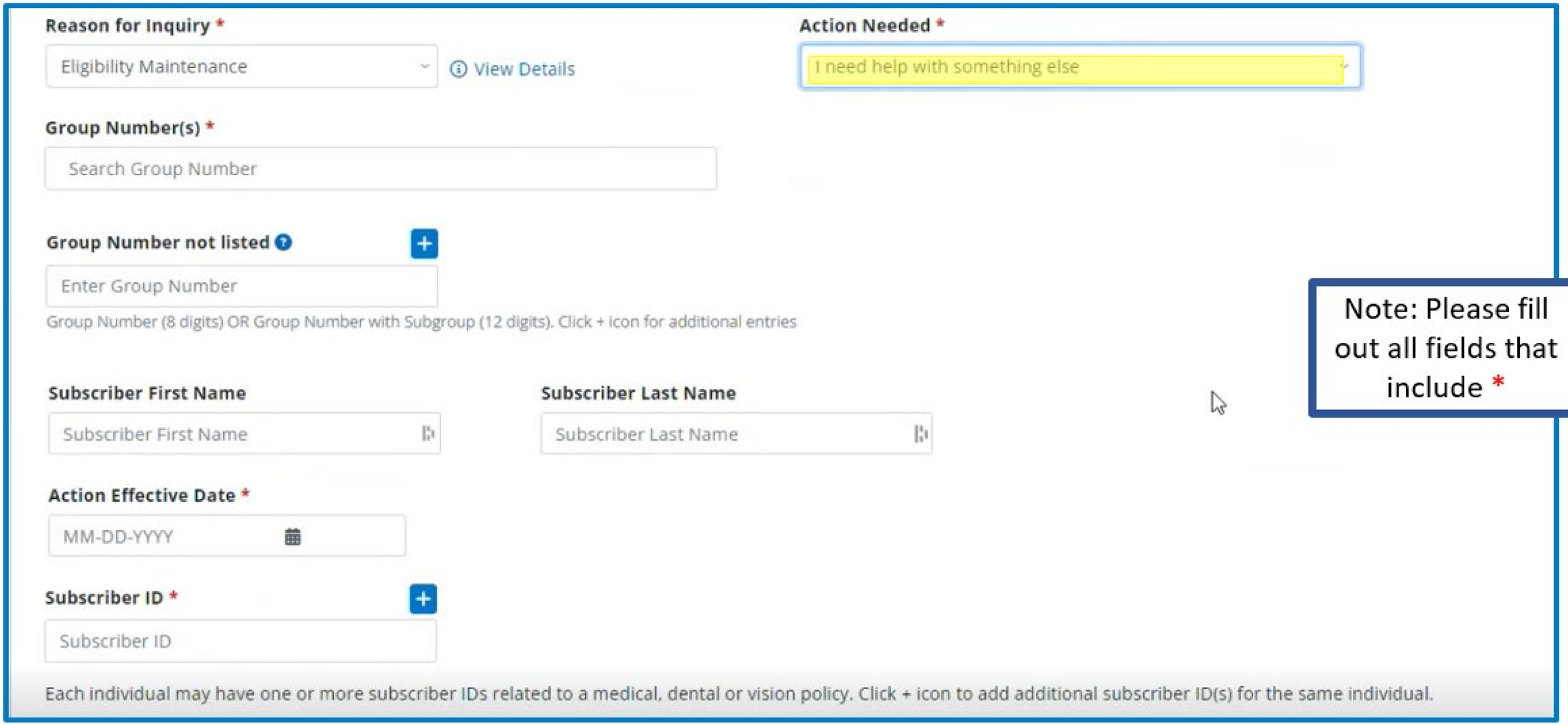
Action Needed: Change plan



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	

Action Needed: I need help with something else



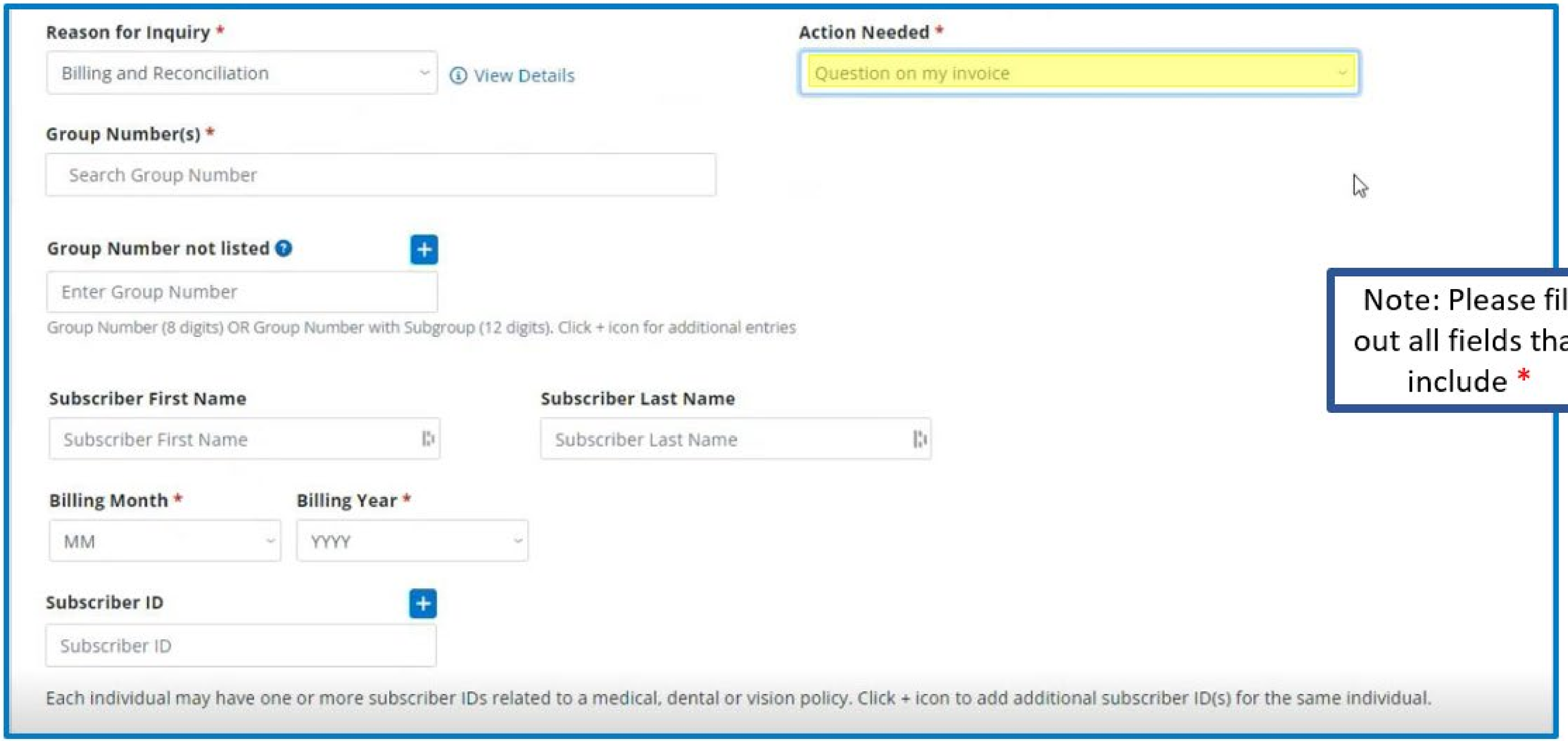
Note: Please fill out all fields that include *

Commercial Group Health Insurance

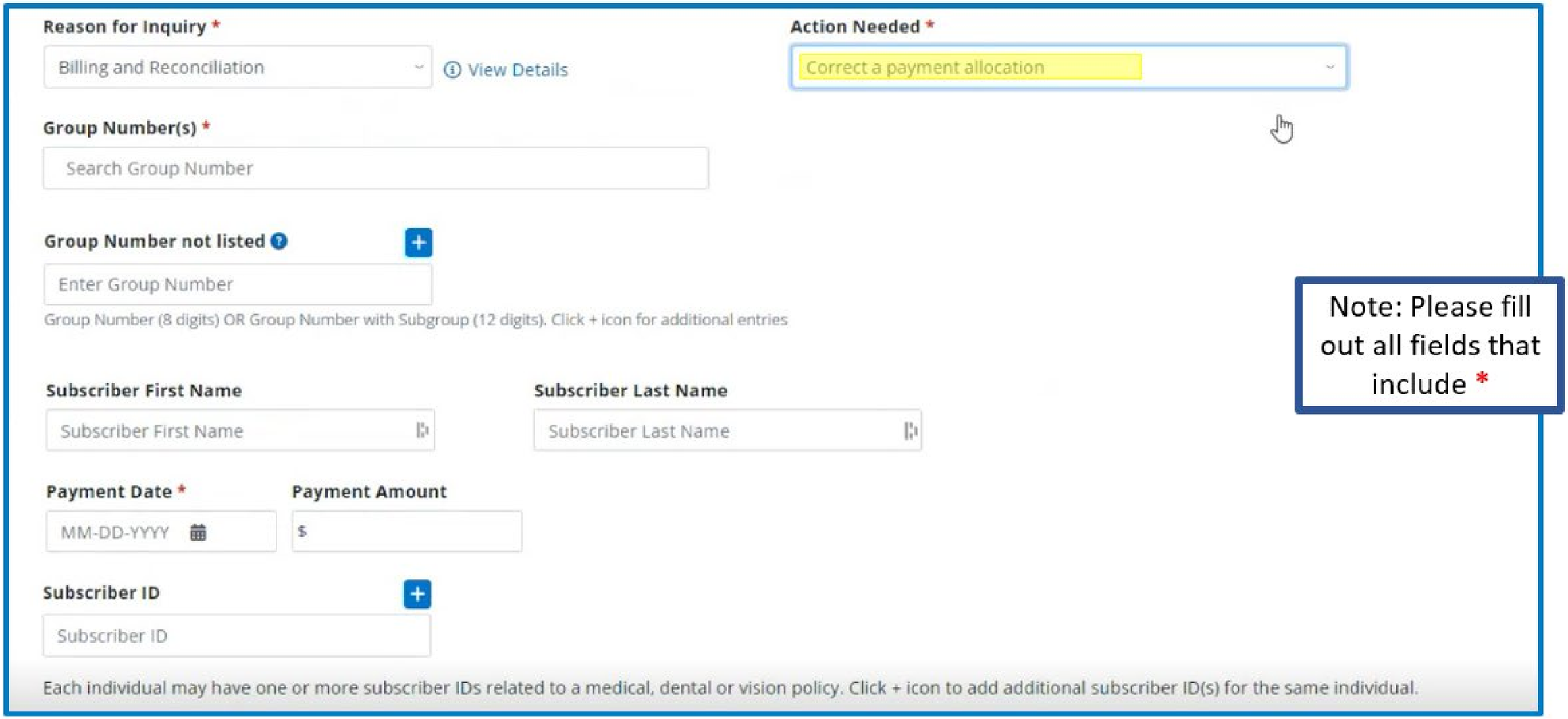
Reason for Inquiry:

Billing and Reconciliation

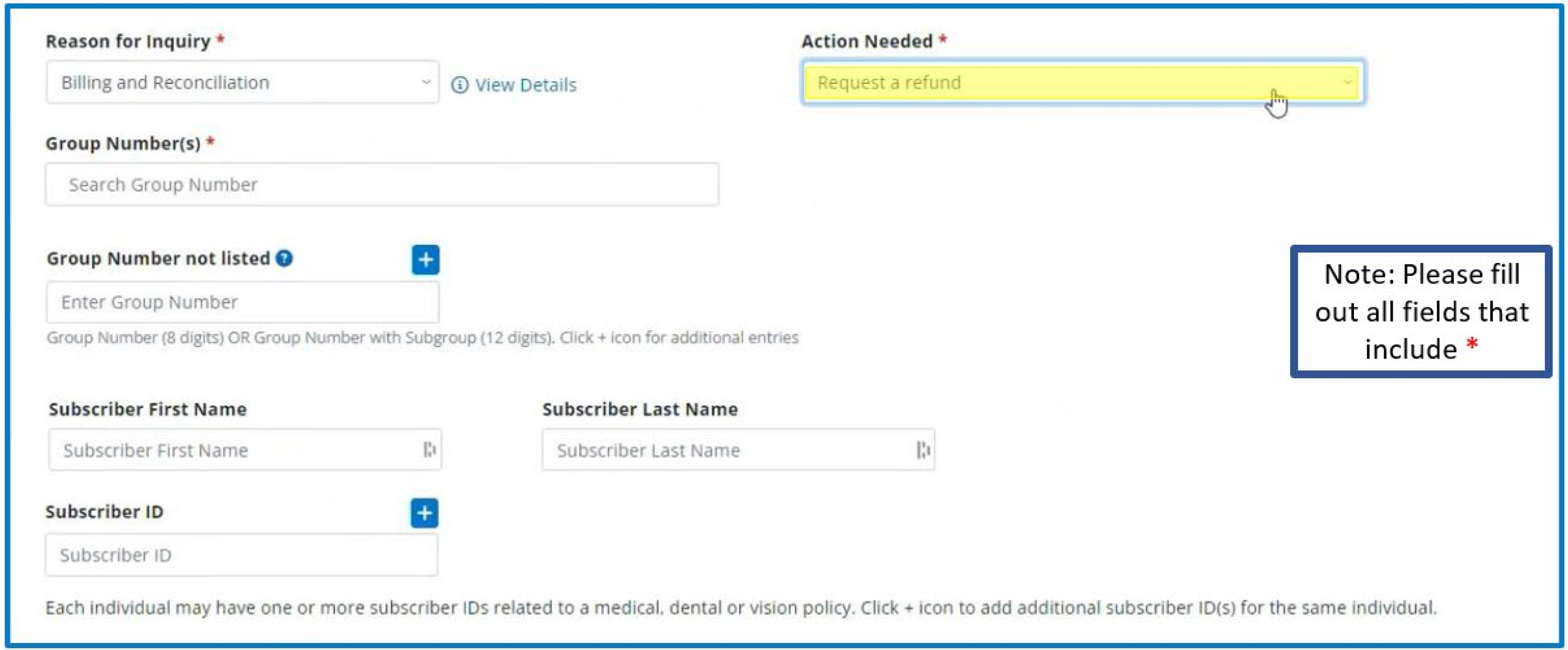
Action Needed: Question on my invoice



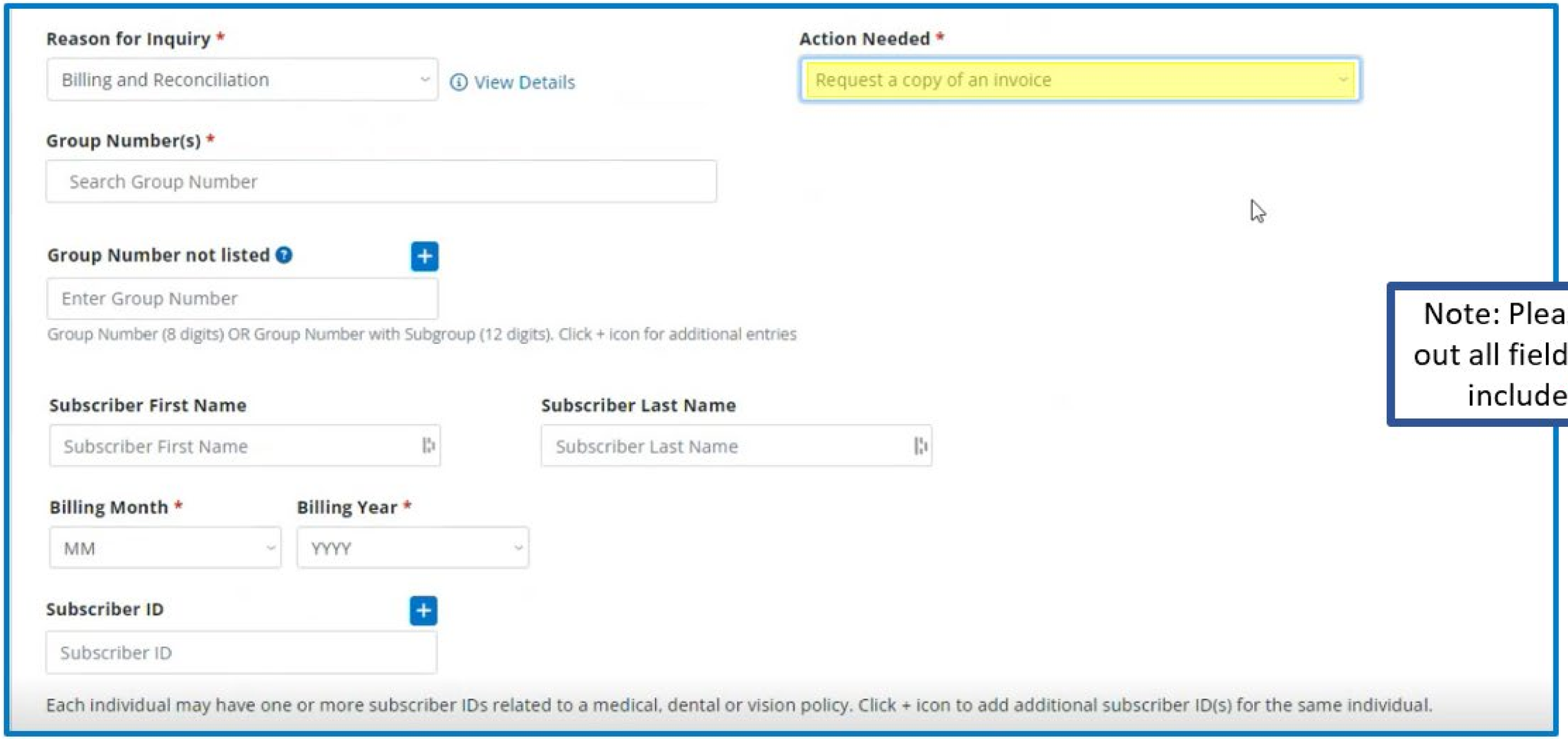
Action Needed: Correct a payment allocation



Action Needed: Request a refund

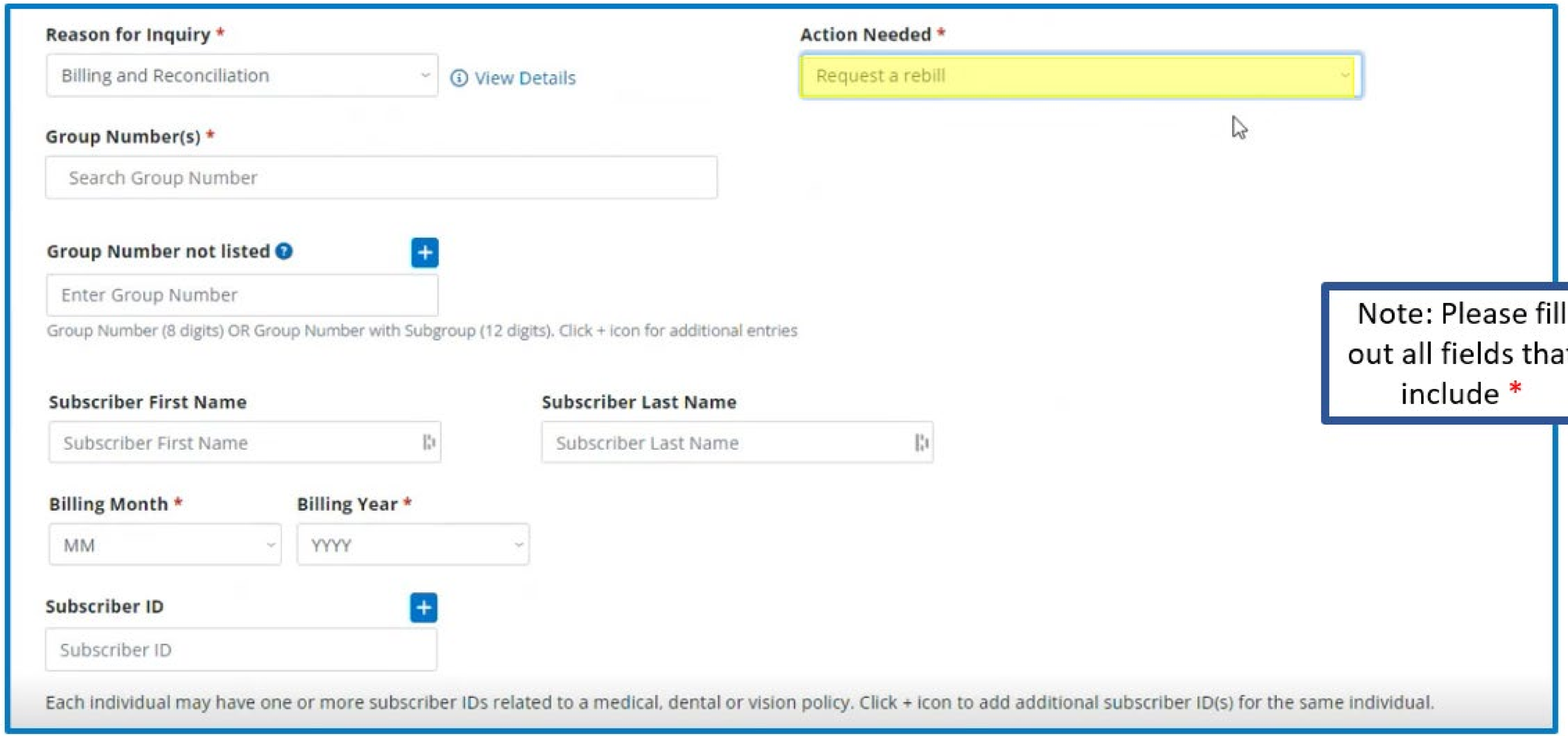


Action Needed: Request a copy of an invoice



Note: Please fill out all fields that include *

Action Needed: Request a rebill



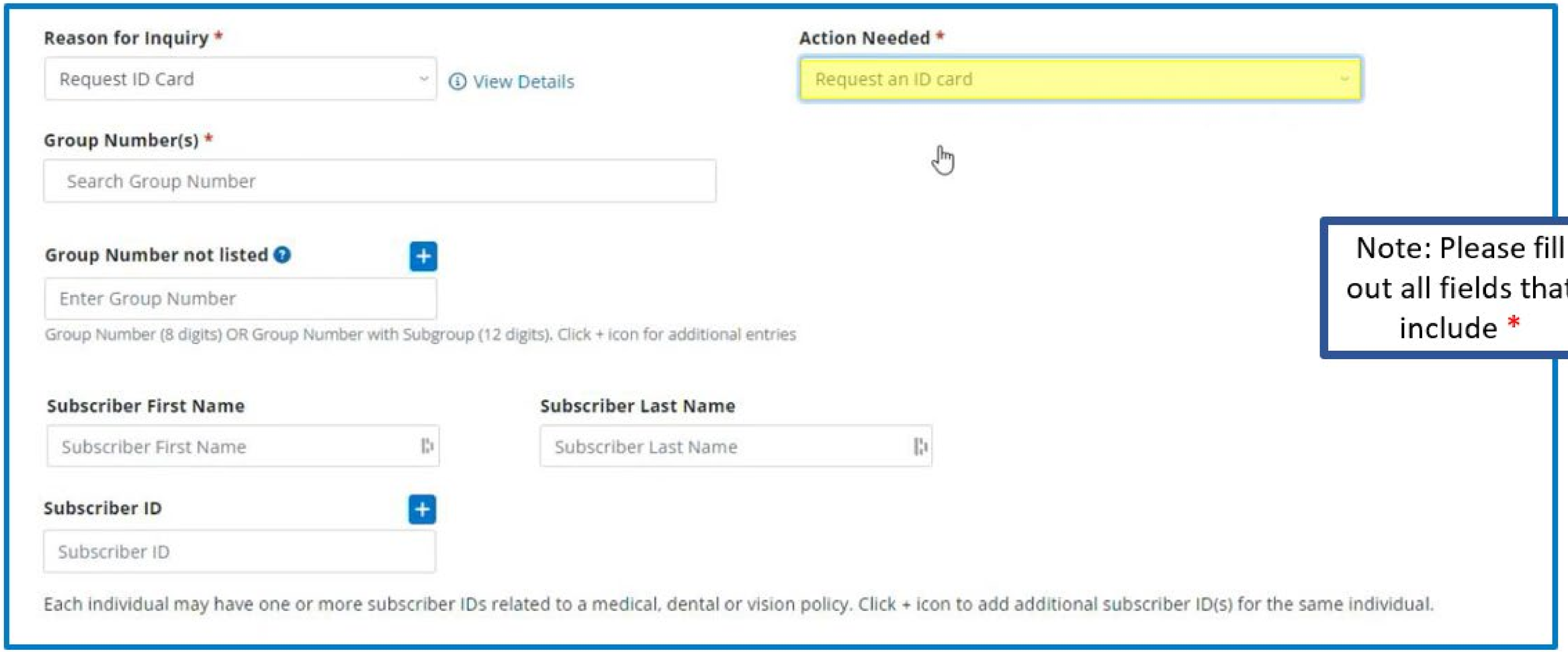
Note: Please fill out all fields that include *

Commercial Group Health Insurance

Reason for Inquiry:

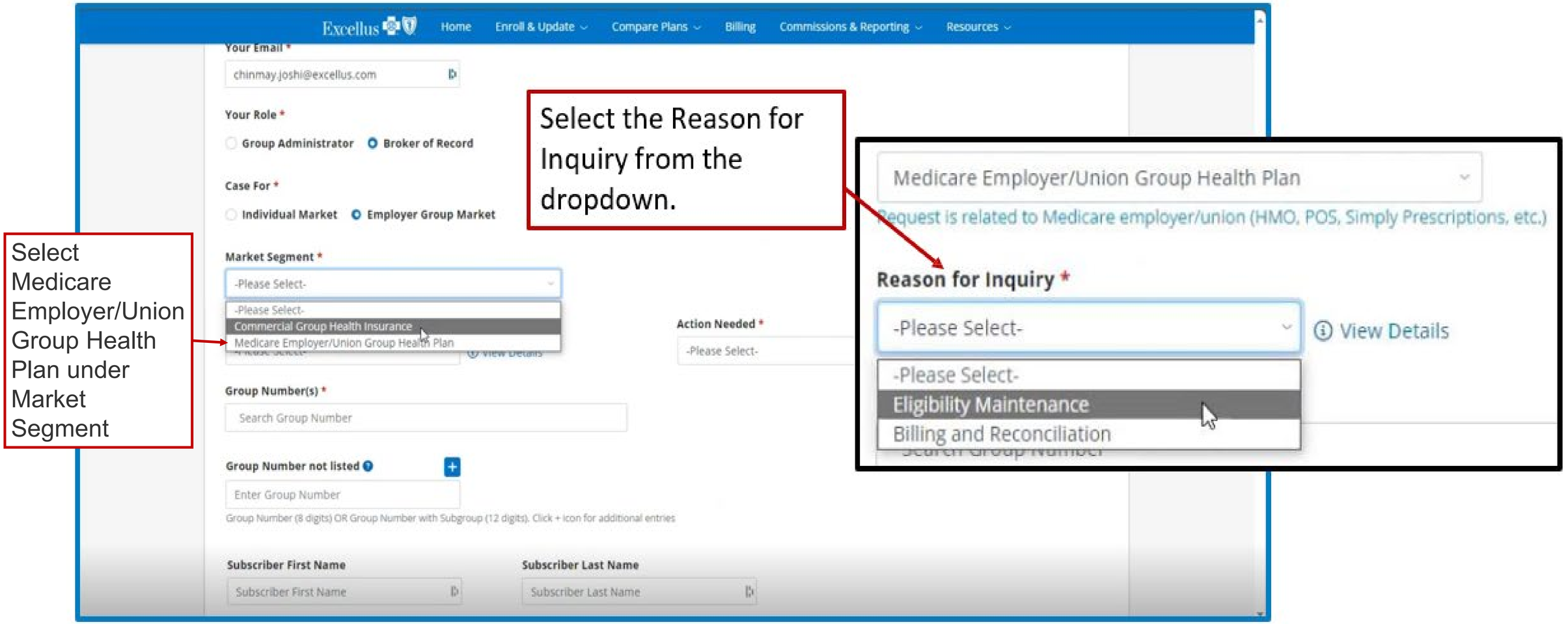
Request Member ID Card

Action Needed: Request an ID Card



Note: Please fill out all fields that include *

Market Segment:
Medicare Employer/Union Group Health Plan

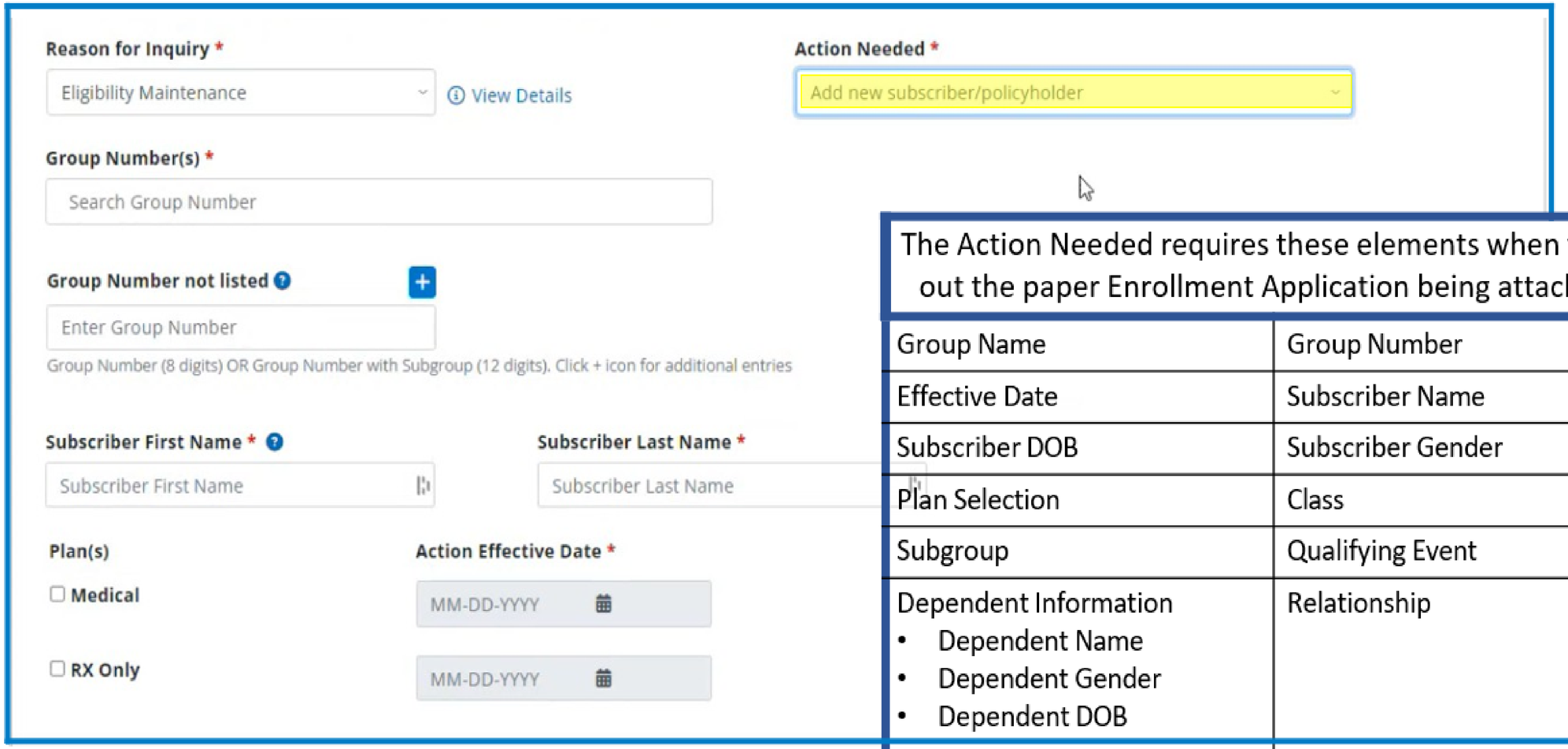


Medicare Employer / Union Group

Reason for Inquiry:

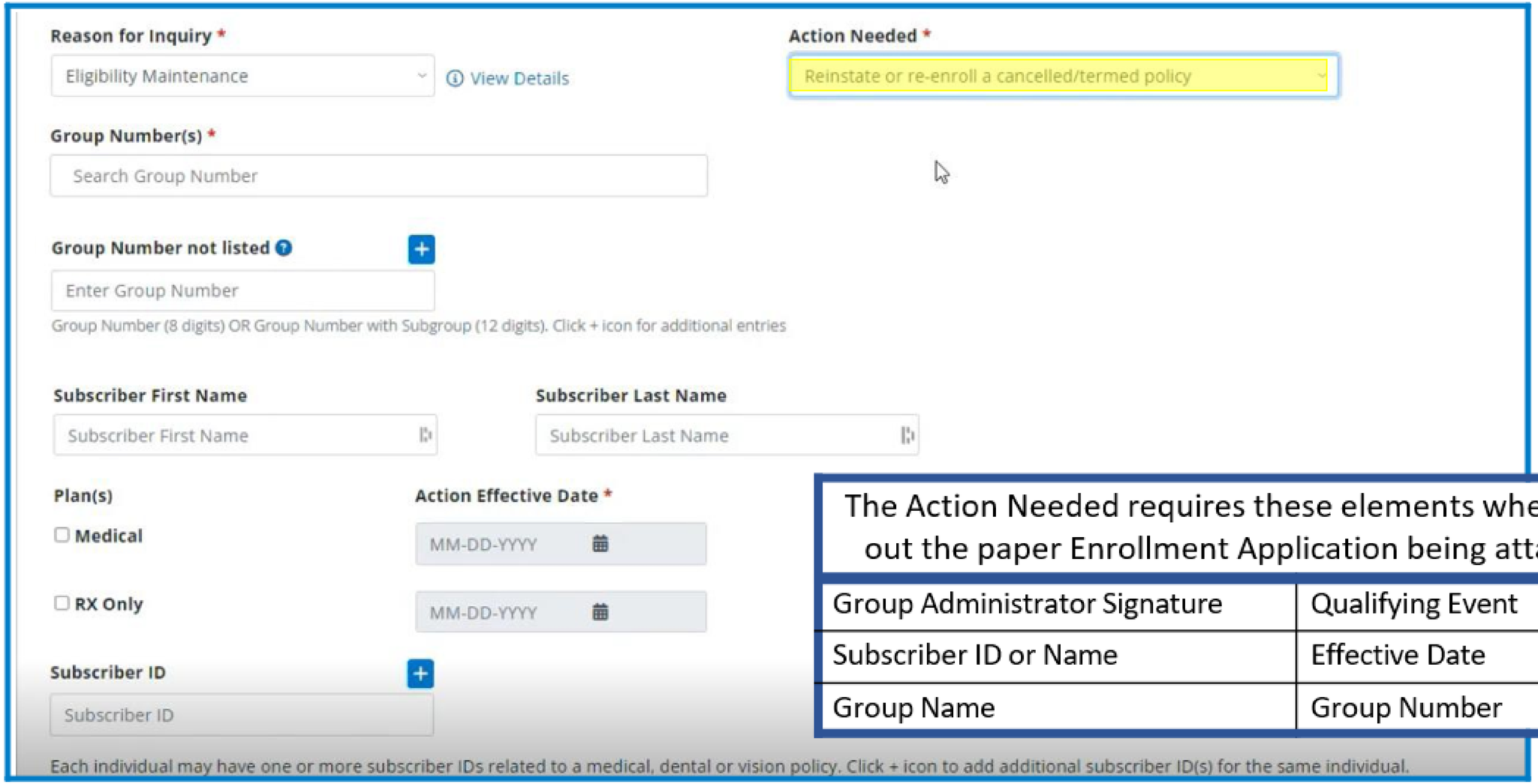
Eligibility Maintenance

Action Needed: Add new 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	

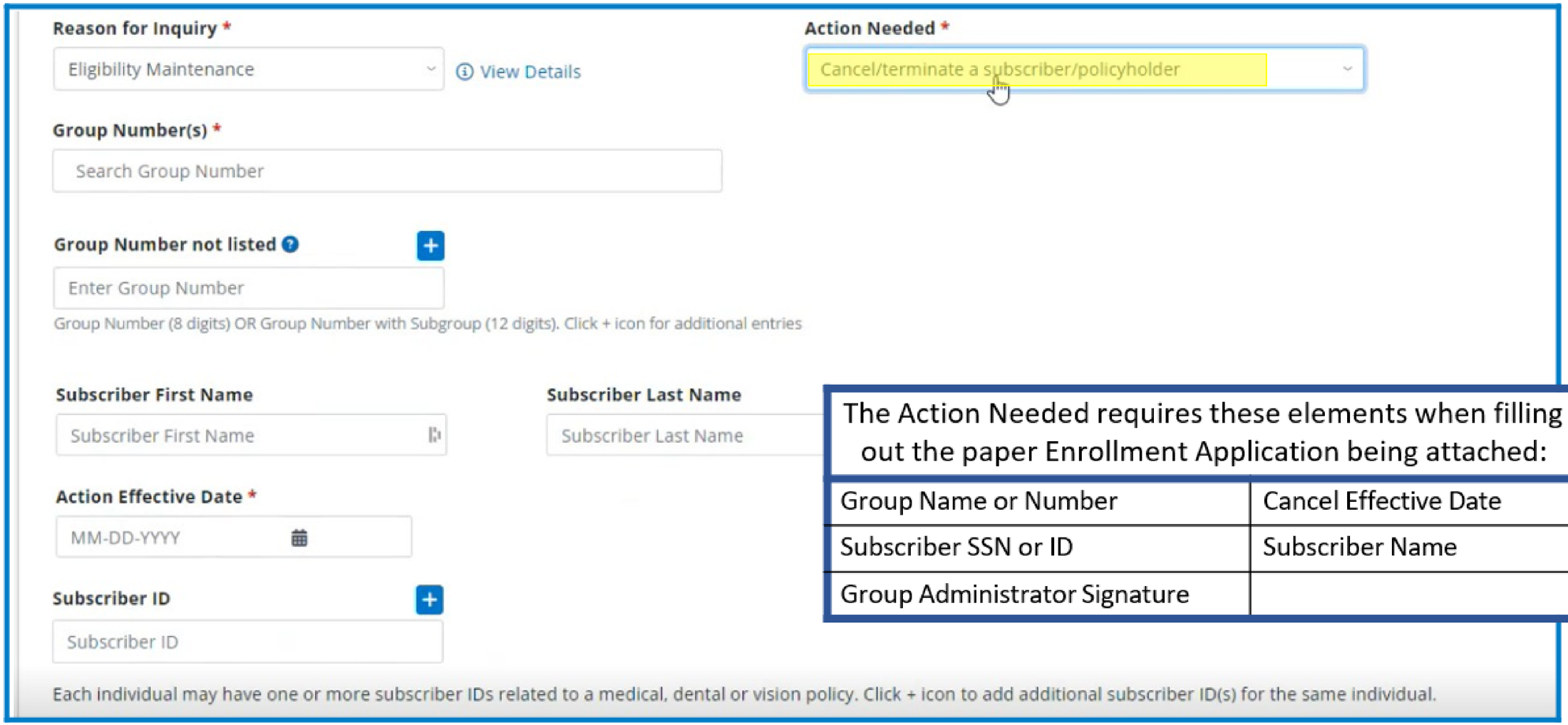
Action Needed: Reinstate or re-enroll a cancelled/termed policy



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

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

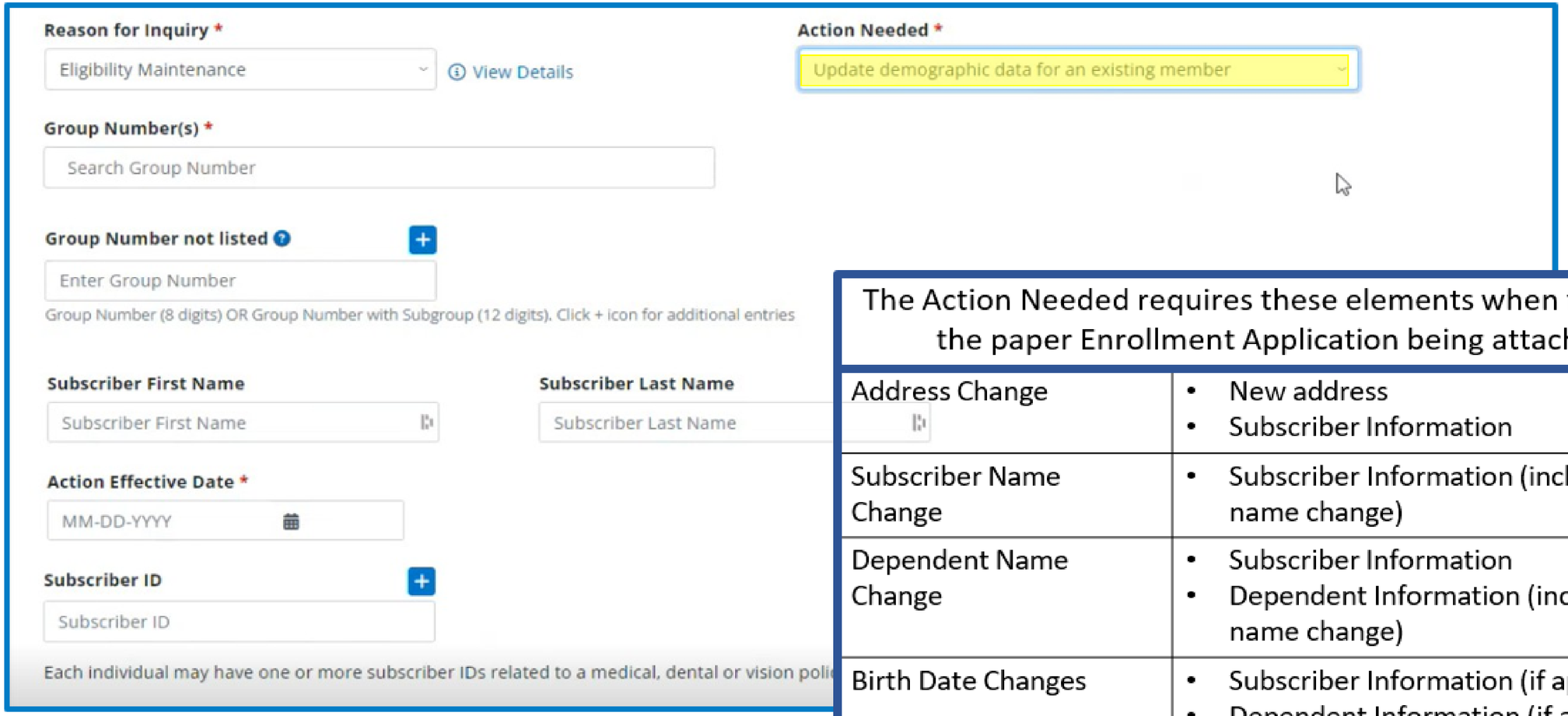
Action Needed: Cancel/terminate a subscriber/policyholder



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

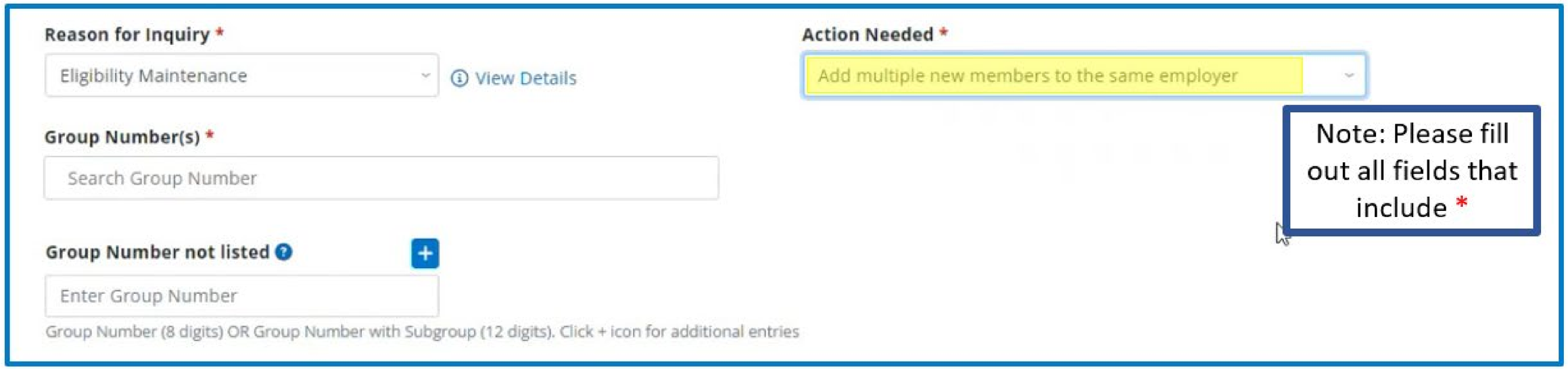
Group Name or Number	Cancel Effective Date
Subscriber SSN or ID	Subscriber Name
Group Administrator Signature	

Action Needed: Update demographic data for an existing member

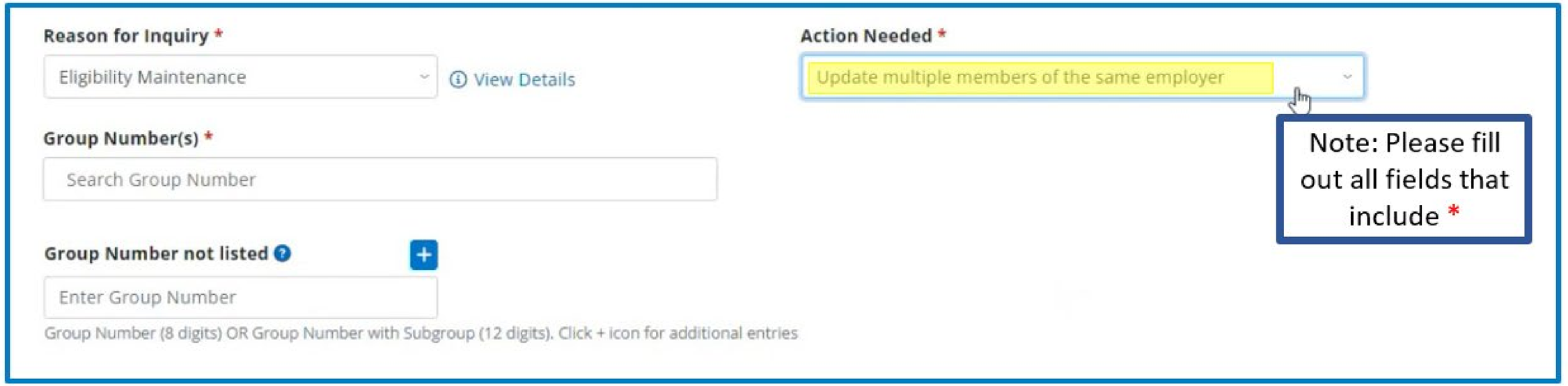


The Action Needed requires these elements when filling out the paper Enrollment Application being attached:	
Address Change	• New address • Subscriber Information
Subscriber Name Change	• Subscriber Information (including name change)
Dependent Name Change	• Subscriber Information • Dependent Information (including name change)
Birth Date Changes	• Subscriber Information (if applicable) • Dependent Information (if applicable)
Gender Changes	• Subscriber Information (if applicable) • Dependent Information (if applicable)

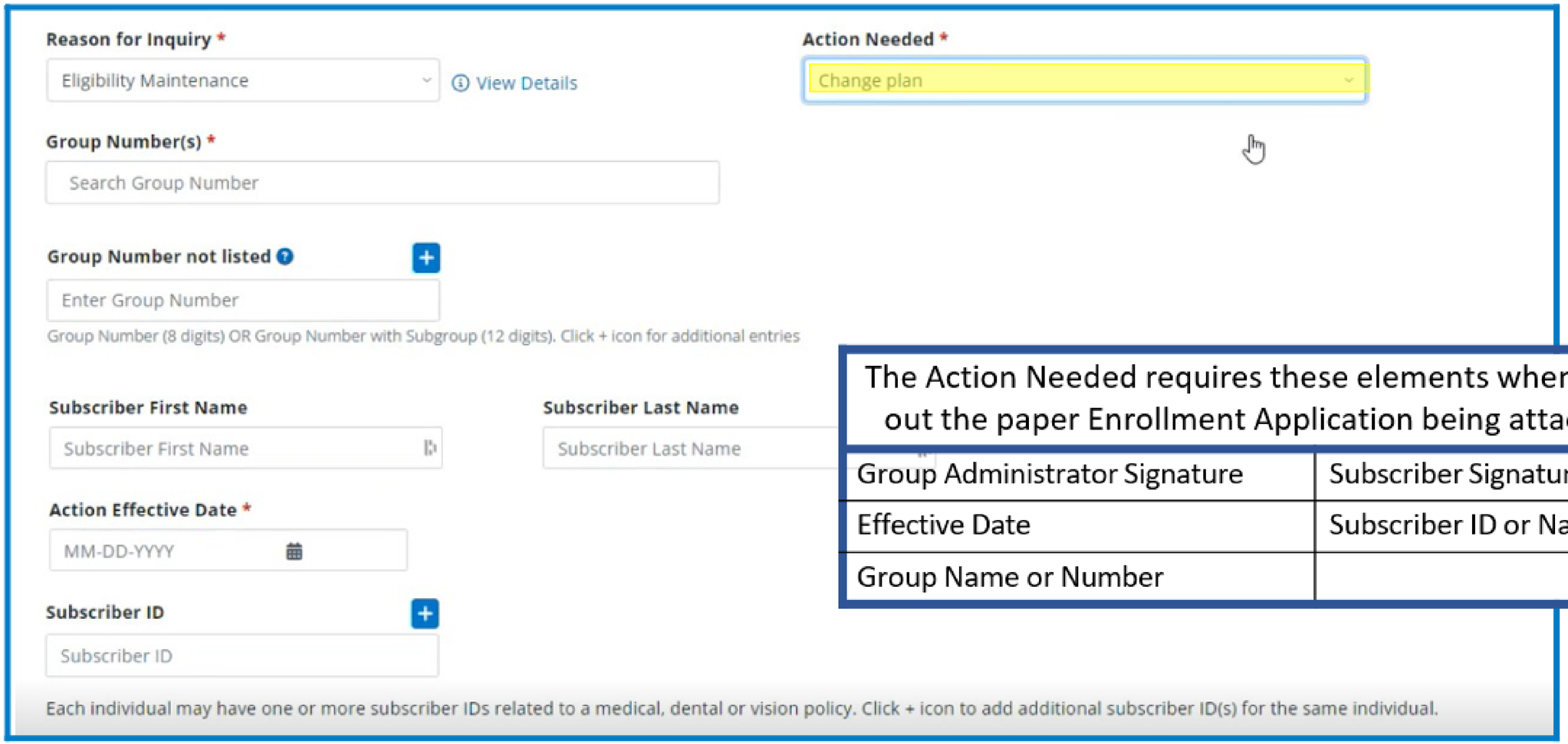
Action Needed: Add multiple new members to the same employer



Action Needed: Update multiple members of the same employer

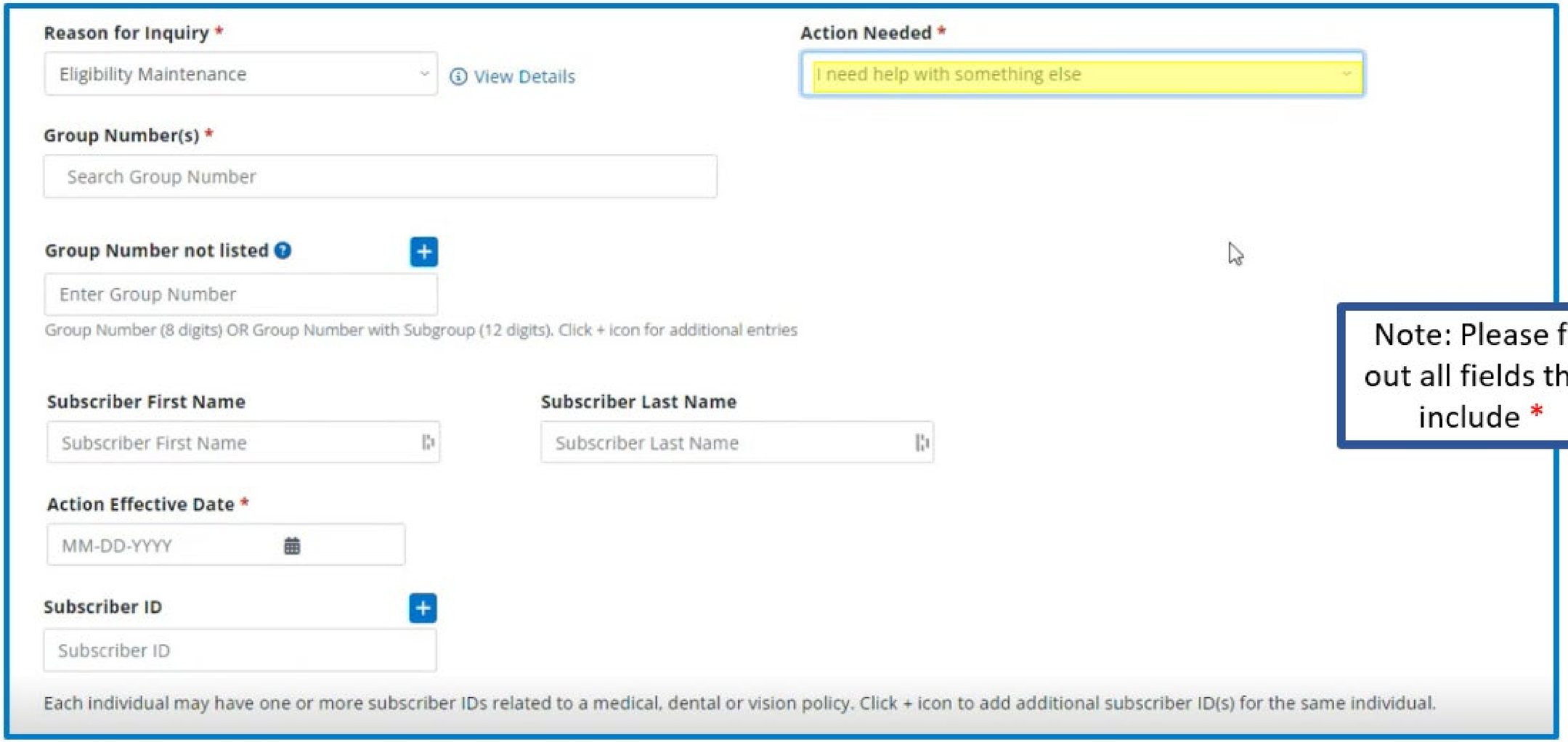


Action Needed: Change plan



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	

Action Needed: I need help with something else



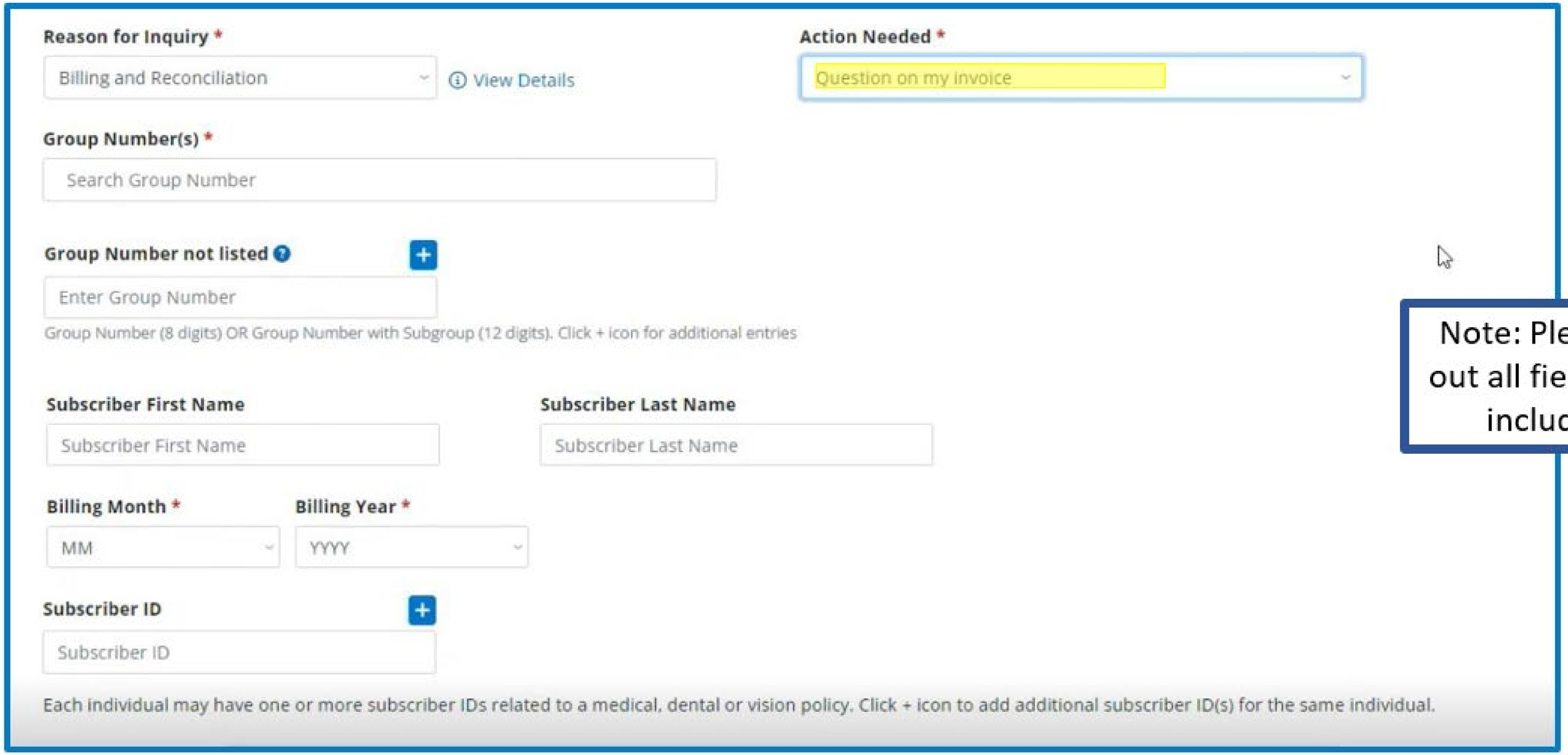
Note: Please fill out all fields that include *

Medicare Employer / Union Group

Reason for Inquiry:

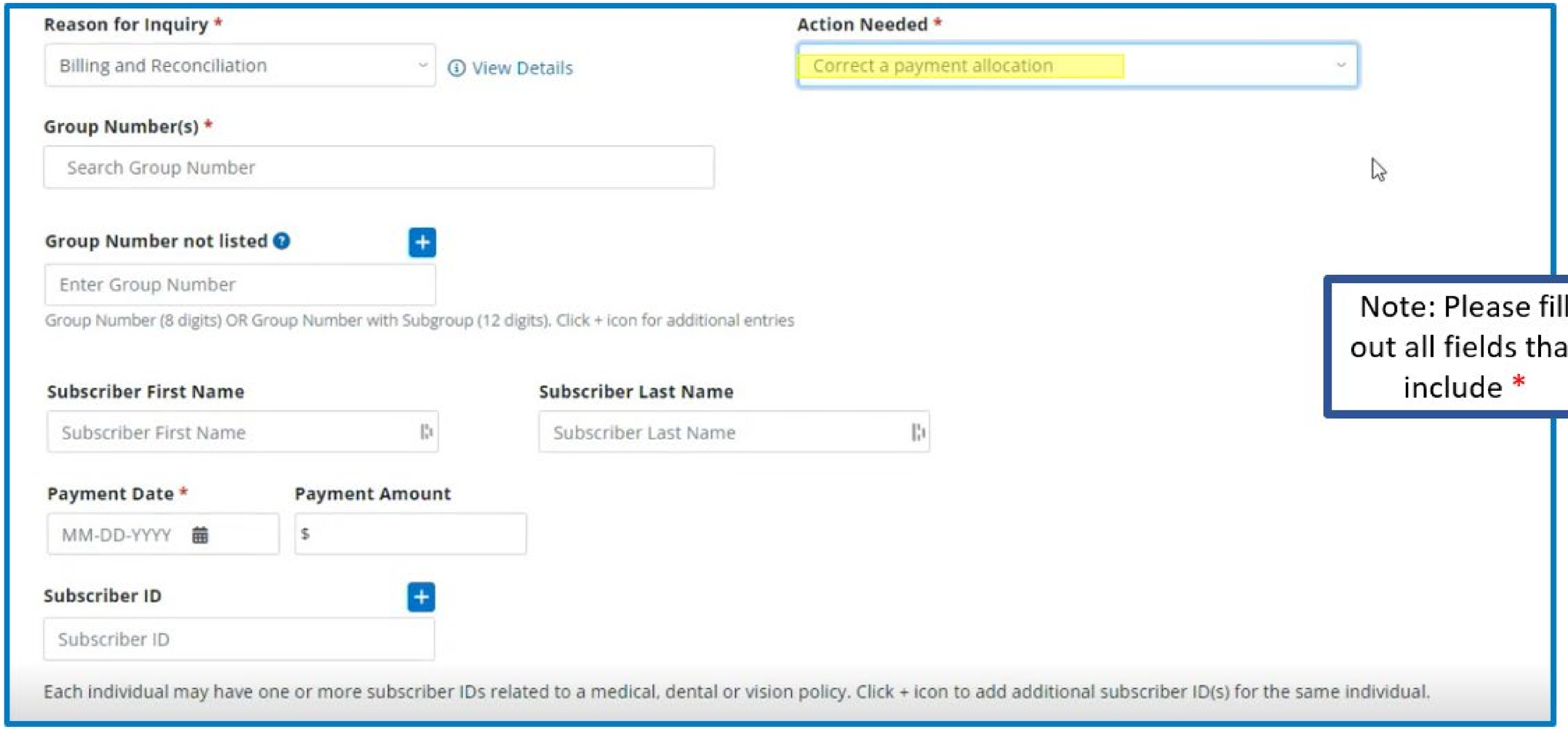
Billing and Reconciliation

Action Needed: Question on my invoice



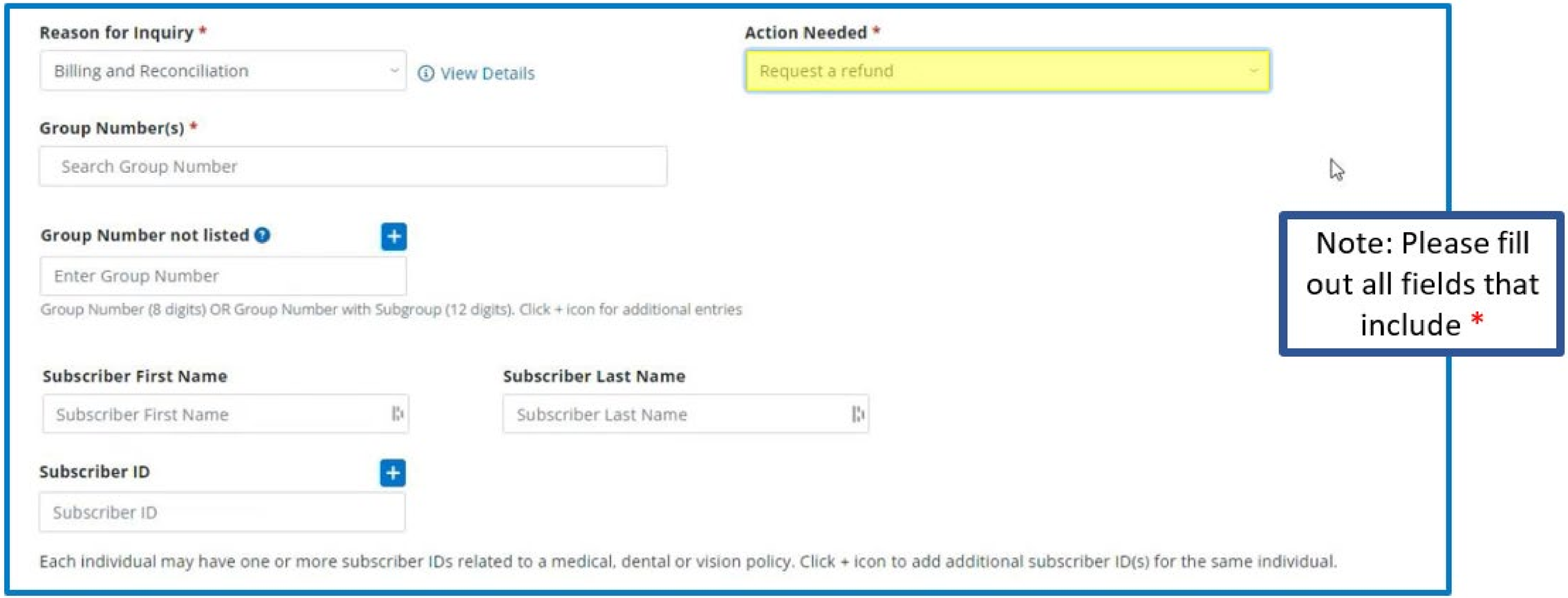
Note: Please fill out all fields that include *

Action Needed: Correct a payment allocation



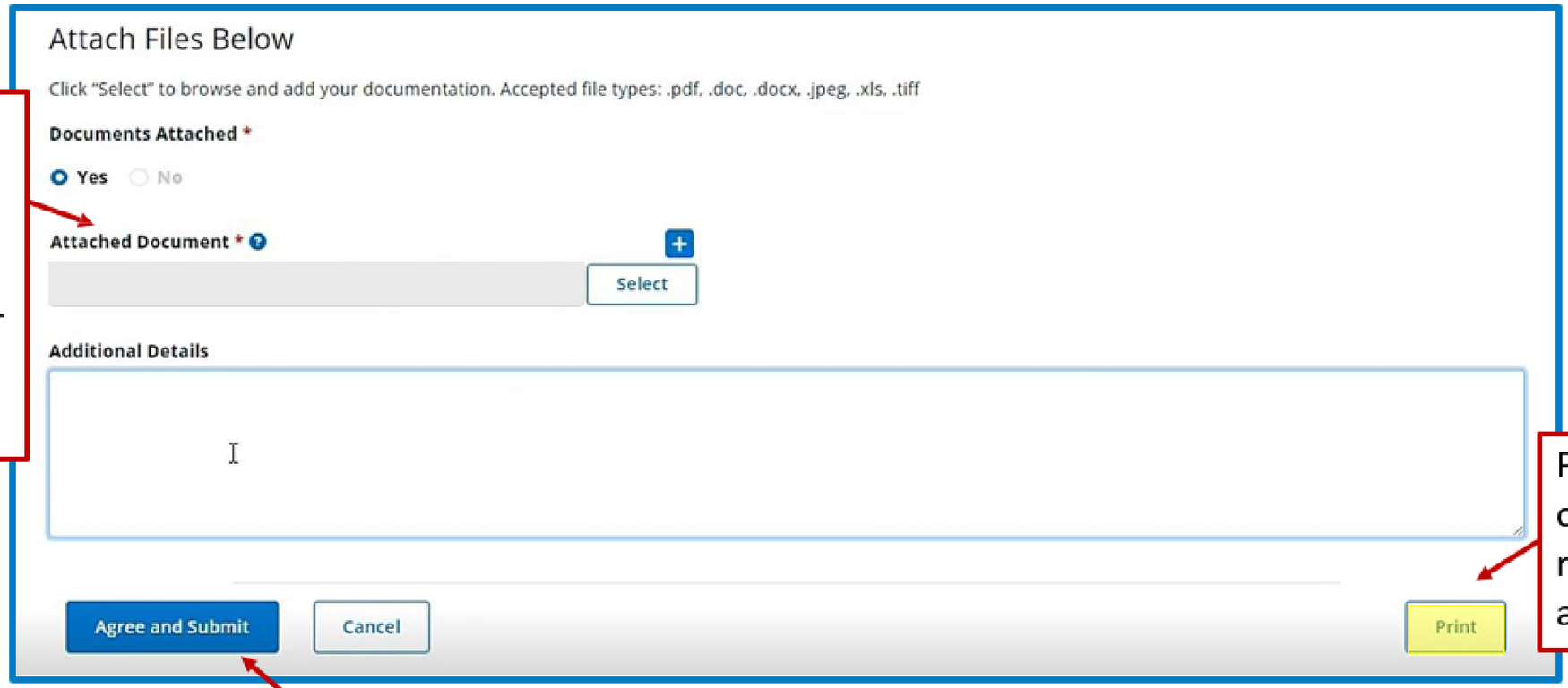
Note: Please fill out all fields that include *

Action Needed: Request a refund



Submitting a Case

Submitting a Case



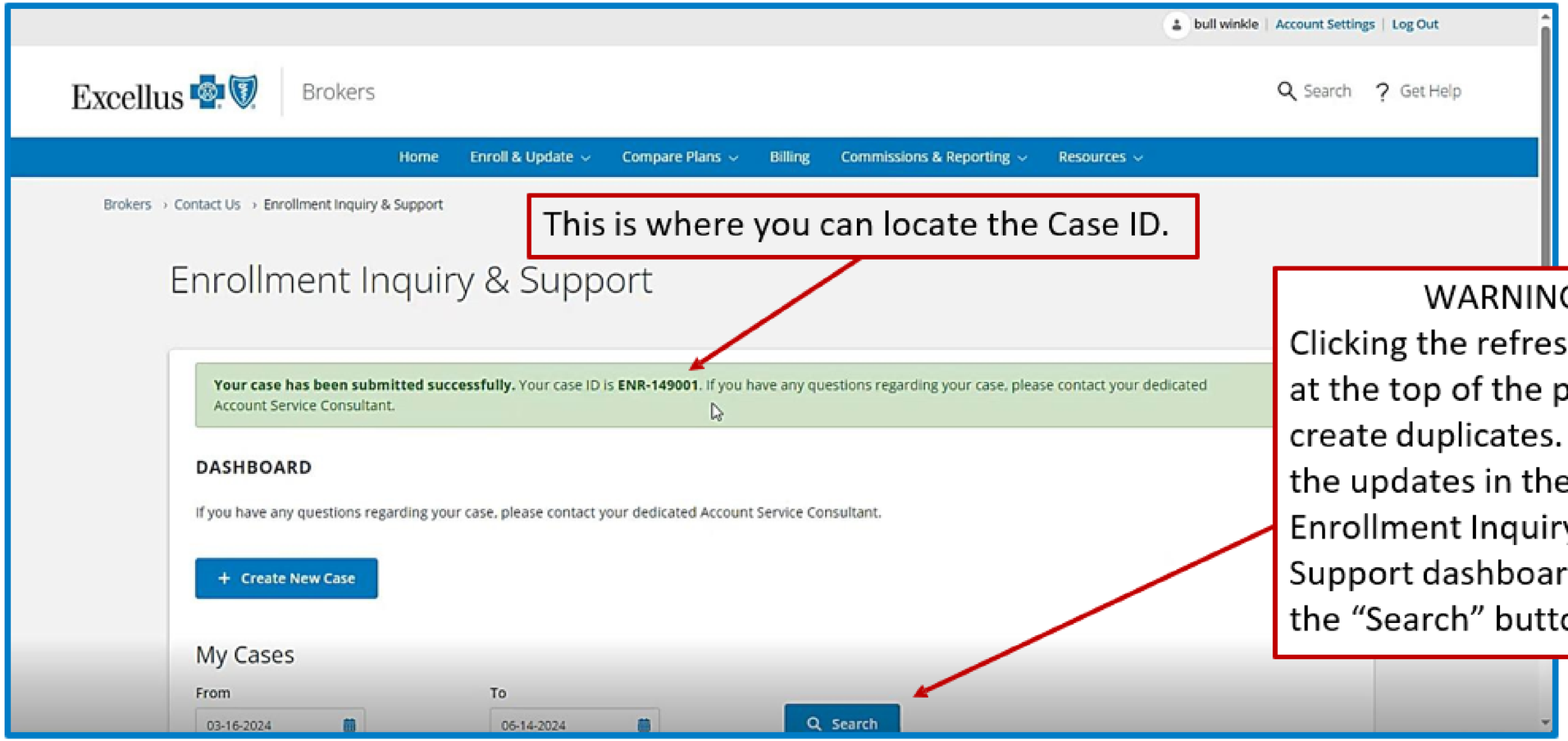
Attach files if needed based on the information provided under Table of Forms section.

Printing a copy of request is available.

When finished, click "Agree and Submit"

Submitting a Case

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



WARNING:
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.

NOTES: