Excellus

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

CAPCO

DO NOT USE - INTERNAL PURPOSES ONLY

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

1 – Group Employer Information – This section should be completed by the Group Benefits Administrator.

Please use blue or black ink, print one character per box

Medical Group Number: 00061707
Dental Group Number: 506572

Department:

CDS ☐ FDD ☐ ES ☐ ECD ☐ ADMIN ☐ WIC ☐

Subscriber Status:

☐ Active

☐☐☐☐☐☐
Effective Date (1st of the month following 60 days)

☐☐☐☐☐☐
Eligibility Date

2 - Subscriber Plan. Please use blue or black ink, print one character per box. Check applicable plan (s).

MEDICAL
Please check coverage type and person(s) to be covered: ❑ Single ❑ Family

❑SB 25-500	❑ Hybrid 1	❑Ded. 3
Copay / Ded $25 PCP/$40 Specialist	Copay / Ded $40 PCP/$60 Specialist	Deductible $6350/$12700
Rx - $5/$35/$70	Rx - $7 Generic Only	Rx – Full Integrated

DENTAL
Please check coverage type and person(s) to be covered:
❑ Single ❑ EE & One ❑ Family

❑ Option 1 (High)	❑ Option 2 (Low)
Benefit Max $1,500	Benefit Max $750
Orthodontia Max - $2,000	No Orthodontia

3 – Reason for Enrollment/Change Subscriber; please indicate the reason for this enrollment or change.

☐ New Hire ☐ Open Enrollment ☐ Loss of Coverage

☐ Add Dependent / Please indicate reason for adding dependent: ☐ Adoption ☐ Marriage ☐ Newborn

4 – Subscriber Information

Please complete both sides of this application. The subscriber signature is required in order to process the application.

Subscriber's Last Name

Subscriber's First Name

Mailing Address

Apt or Suite

City

State

Zip Code

Date of Birth

Gender ☐ M ☐ F

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced/Marital

Status Event Date

Medicare Number (if Applicable)

Part A Date

Part B Date

If Medicare eligible due to ESRD please check type of dialysis: ☐ Self administered ☐ Facilitated

Date started

Return Original to Excellus BlueCross BlueShield, at above address – Copy: Employer Group

5 – Other Coverage Information
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? ☐ No ☐ Yes / Dental? ☐ No ☐ Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? ☐ No ☐ Yes / Dental? ☐ No ☐ Yes

Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: Effective Date Termination Date

6 – Cancellation Information – Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ☐ Medical ☐ Dental / Reason _____ Date

Dependent (list each dependent in section 7) ☐ Medical ☐ Dental / Reason _____ Date

7 – Dependent Information – Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name

☐ Male ☐ Female Date of Birth Social Security Number Are you enrolling as a Domestic Partner? ☐ Yes ☐ No

Medicare Number (if Applicable) Part A Date Part B Date

Dependent's Last Name Dependent's First Name

☐ Male ☐ Female Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? (see last page for additional information) ☐ Yes ☐ No

Is Dependent a full time student? ☐ Yes ☐ No If yes, please indicate college/university name:

College/University Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name

☐ Male ☐ Female Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? (see last page for additional information) ☐ Yes ☐ No

Is Dependent a full time student? ☐ Yes ☐ No If yes, please indicate college/university name:

College/University Expected Graduation Date Credit hours

8- Release/Signature – Subscriber signature required. You must sign and date this form to be eligible for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature _____ Date _____

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9 – Additional Dependents – Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Dependent's Last Name Dependent's First Name

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
Female (see last page for additional information) No

Is Dependent a full time student? Yes No If yes, please indicate college/university name:
College/University Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
Female (see last page for additional information) No

Is Dependent a full time student? Yes No If yes, please indicate college/university name:
College/University Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
Female (see last page for additional information) No

Is Dependent a full time student? Yes No If yes, please indicate college/university name:
College/University Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
Female (see last page for additional information) No

Is Dependent a full time student? Yes No If yes, please indicate college/university name:
College/University Expected Graduation Date Credit hours

Dependent's Last Name Dependent's First Name

Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? Yes
Female (see last page for additional information) No

Is Dependent a full time student? Yes No If yes, please indicate college/university name:
College/University Expected Graduation Date Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. 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/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

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

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

- ☐ check Subscriber box
- ☐ check Products to be cancelled (Medical, Dental)
- ☐ indicate Cancellation Date in space provided
- ☐ complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible
Commercial
COBRA Begin Date
COBRA Handicapped/Disabled Date
Transfer to Traditional
Transfer to HMO
Transfer to POS
COBRA End Date
Subscriber Request
Subscriber Deceased
Spouse's Insurance
Medicaid
Medicare

To Cancel a Dependent using the

- ☐ check Dependent box
- ☐ check Products to be cancelled (Medical, Dental)
- ☐ indicate Cancellation Date in space provided
- ☐ complete Subscriber Information
- ☐ complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law
Dependent Over Age
Deceased
Ineligible Student
COBRA Begin Date
Subscriber
Request Divorce
Medica
re

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

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than seven dependents please use an additional form.
QUALIFIED GUIDELINES:

- ☐ A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- ☐ Must be under the eligible child age for your employer group:
  - natural, adopted or stepchild
- ☐ Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- ☐ I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- ☐ In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- ☐ If this application is made on behalf of a minor, the responsible party must complete the application.
- ☐ By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- ☐ I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- ☐ I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- ☐ **PREFERRED PROVIDER ORGANIZATION (PPO)**
  I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- ☐ The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

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

If you have any questions, please contact your Group Administrator/Representative.
Or, visit us at:
www.excellusbcbs.com