# 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

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Association/Chamber Name (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Administrator's Signature (required)</td>
<td>Date</td>
</tr>
<tr>
<td>Employee Number</td>
<td>Department Number</td>
</tr>
<tr>
<td>Medical Information</td>
<td>Subscriber Information</td>
</tr>
<tr>
<td>Medical Group Number (8 digits)</td>
<td>Medical Plan Selection</td>
</tr>
<tr>
<td>Medical Subgroup Number (4 digits)</td>
<td>Medical Effective Date</td>
</tr>
<tr>
<td>Medical Class Number (4 digits)</td>
<td>Dental Information</td>
</tr>
<tr>
<td>Medical Group Number (8 digits)</td>
<td>Dental Group Number</td>
</tr>
<tr>
<td>Medical Subgroup Number (4 digits)</td>
<td>Dental Subgroup Number</td>
</tr>
<tr>
<td>Medical Class Number (4 digits)</td>
<td>Dental Class or Package #</td>
</tr>
<tr>
<td>Medical Effective Date</td>
<td>Dental Effective Date</td>
</tr>
</tbody>
</table>

## Section 2: Subscriber's Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (e.g., Jr, Sr, III, etc.)</th>
<th>Birthdate:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Social Security Number**</td>
<td></td>
<td>Date of Hire/Rehire:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retire Date:</td>
<td></td>
<td>Marital Status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Single</td>
<td>Married</td>
<td>Legally Separated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age 65+</td>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>End Stage Renal *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscriber’s Medicare Number (if applicable)</td>
<td></td>
<td>Marital Status Event Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A Effective Date</td>
<td>Part B Effective Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

APP-352 (0618) [E Signature Series]
### 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

### 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?

**Subscriber**

<table>
<thead>
<tr>
<th>Cancel Code</th>
<th>Medical Cancel Date</th>
<th>Dental Cancel Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB02-Left Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SB05-Per Group Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SB06-Subscriber Request (voluntary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SB07-Deceased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SB09-Enrolled in Error</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dependent(s)**

<table>
<thead>
<tr>
<th>Dependent Name</th>
<th>Cancel Code</th>
<th>Medical Cancel Date</th>
<th>Dental Cancel Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M001-Per Group Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M002-Deceased</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M003-Per Subscriber Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M004-Enrolled in Error</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M005-Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M007-Per Member Request (voluntary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M008-Moved Out of Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M010-Overage Dependent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M011-No Longer a Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M013-Ineligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M014-YAO Ineligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M040-Mx Same Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- ☐ Spouse
- ☐ Domestic Partner
- ☐ Dependent Child
- ☐ Disabled Dependent Child (Separate application form required)
- ☐ Other: ______________________

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

- Gender:
  - ☐ Male
  - ☐ Female
  - Birthdate: _____ / _____ / ________

- Is dependent a full time student over age 19?  ☐ Yes  ☐ No
  - If yes, please provide name of college/university: ______________________
  - Expected Graduation Date: ____ / ____ / ______

- Medicare Eligible: ☐ Yes  ☐ No
  - If yes, indicate reason: ☐ Age 65+
  - Part A Effective Date: ____ / ____ / ______
  - ☐ Disability
  - ☐ End Stage Renal *
  - Part B Effective Date: ____ / ____ / ______

- Medicare Number (if applicable)

↓ Additional Dependent(s) ↓

- ☐ Dependent Child
- ☐ Disabled Dependent Child (Separate application form required)
- ☐ Other: ______________________

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

- Gender:
  - ☐ Male
  - ☐ Female
  - Birthdate: _____ / _____ / ________

- Is dependent a full time student over age 19?  ☐ Yes  ☐ No
  - If yes, please provide name of college/university: ______________________
  - Expected Graduation Date: ____ / ____ / ______

- Medicare Eligible: ☐ Yes  ☐ No
  - If yes, indicate reason: ☐ Age 65+
  - Part A Effective Date: ____ / ____ / ______
  - ☐ Disability
  - ☐ End Stage Renal *
  - Part B Effective Date: ____ / ____ / ______

- Medicare Number (if applicable)
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?  _____ /_____ /________

Policyholder’s name _______________________________

ID# __________________________

Who did the insurance cover?

☐ Self Only  ☐ Self & Spouse/Domestic Partner  ☐ Self & Child(ren)  ☐ Family

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?  _____ /_____ /________

Policyholder’s name _______________________________

ID# __________________________

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.

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 out-of-network benefit that 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.

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 __________________________
## Instructions for completing the Group Health Insurance Application

### Section 1: Employer Group & Benefit Information
This section should be completed with your Group Administrator. Group Administrator’s signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber’s status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

### 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.

### 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 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.

### 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.