Excellus

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

CEWW Health Insurance Consortium GROUP ENROLLMENT FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#________________________________

EC_____________________________________

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.
This application cannot be processed without this information and a signature.

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

Group # 0 0 0 3 4 2 8 0

Subgroup # ☐☐☐☐

Class# ☐☐☐☐

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature/Date

X

Subscriber Status:

☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:

☐ Left Employ/Retirement ☐ Death of Spouse

☐ Divorce/Legal Separation ☐ Dependent Reached Max Age

☐ Other __________________

Effective Date ☐☐☐☐☐☐

COBRA Effective Date ☐☐☐☐☐☐

Hire/Rehire Date ☐☐☐☐☐☐

Retired Effective Date ☐☐☐☐☐☐

2 – Subscriber Plan Selection

Department # ☐☐☐☐☐☐☐☐ Employee # ☐☐☐☐☐☐☐☐☐☐

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

☐ Platinum Plan 1 (WN)

☐ Platinum Plan 2 (WO)

☐ Signature Ded 3 (DAG)

Please check coverage type and person(s) to be covered:

☐ Medical ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐ End Stage Renal Disease

☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Age 65+ ☐ Remove Dependent ☐ Marital Status Change

☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Newborn ☐ Disability

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

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

Middle Initial

Title

E-mail Address

Mailing Address

Apt or Suite

City

State

Zip

Work Phone Number ☐☐☐-☐☐☐-☐☐☐☐/

Home Phone Number ☐☐☐-☐☐☐-☐☐☐☐/

Cell Phone Number ☐☐☐-☐☐☐-☐☐☐☐

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 Effective Date ☐☐☐☐☐☐

Part B Effective Date ☐☐☐☐☐☐

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

5 – Other Coverage Information Have you ever been a member of Excellus BlueCross BlueShield? ☐ Yes ☐ No

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Are you or any member of your family enrolled in any other health insurance policy (including Medicare or Medicaid)? Health? ☐ No ☐ Yes

If answering "Yes", are you keeping the additional health or dental coverage? Health? ☐ 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 /Reason_____ Date

Dependent (list each dependent in section 7)

☐ Medical / Reason _____ Date

7 – Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Spouse Partner Last Name Spouse Partner First Name M.I.

☐ Male Date of Birth Social Security Number*

☐ Female

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

---

Dependent's Last Name Dependent's First Name M.I.

☐ Male Date of Birth Social Security Number* Is your over-age dependent handicapped or disabled? ☐ Yes

☐ Female (See last page for additional information) ☐ No

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

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.

I have thoroughly read, understand and agree to comply with the terms of the release.

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**_____

Excellus

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

CEWW Health Insurance Consortium GROUP ENROLLMENT FORM

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

PLEASE PRINT CLEARLY

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 | M.I.

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

Dependent's Last Name | Dependent's First Name | M.I.

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

Dependent's Last Name | Dependent's First Name | M.I.

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

Dependent's Last Name | Dependent's First Name | M.I.

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

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 Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical)
- 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 Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical)
- 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
Medicare

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.
*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

QUALIFIED GUIDELINES:

- A legal spouse (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- 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.

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

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى المستند المرفق لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان سے مدد دستیاب ہے۔ ہمارے ساتھ رابطہ کرنے کے طریقوں کے بارے میں جاننے کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495