EBS Benefit Solutions
An Excellus Company

COBRA ☐ ACTIVE ☐ RETIREE ☐

344 South Warren Street
P.O. Box 4982
Syracuse, New York 13221

MEMBERSHIP APPLICATION

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

PLEASE INDICATE: NEW ADDITION _____ **EXISTING SUBSCRIBER** _____ **TERMINATION** _____

LAST NAME: | FIRST | INITIAL | TITLE | IDENTIFICATION NUMBER

STREET ADDRESS: | C/O | COUNTY

CITY: | STATE: | ZIP CODE:

SEX: ☐MALE ☐FEMALE | DATE OF BIRTH MO / DAY / YR | MARITAL STATUS: ☐SINGLE ☐MARRIED | MARRIAGE DATE MO / DAY / YR

NAME OF EMPLOYER: | GROUP NUMBER: | EMPLOYMENT DATE:

ADDRESS OF EMPLOYER: | PAYROLL NUMBER & LOCATION:

FEDERAL MEDICARE CLAIM NUMBER: _____
☐MEDICARE PART A EFF. DATE _____
☐MEDICARE PART B EFF. DATE _____

LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE.
PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS.

LAST NAME (IF DIFF.)	FIRST NAME	DATE OF BIRTH MO	DAY	YR	RELATIONSHIP HUS	WIF	SON	DAU	SOCIAL SECURITY #	IF STUDENT NAME OF SCHOOL	CREDIT HOURS	GRAD. DATE	IS MEMBER DISABLED	CHECK BOXES IF MEMBER HAS MEDICARE
														Federal Medicare Claim No.: ☐Part A Eff. Date: ☐Part B Eff. Date:
														Federal Medicare Claim No.: ☐Part A Eff. Date: ☐Part B Eff. Date:
														Federal Medicare Claim No.: ☐Part A Eff. Date: ☐Part B Eff. Date:
														Federal Medicare Claim No.: ☐Part A Eff. Date: ☐Part B Eff. Date:

1. On the effective date of this contract have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
HEALTH Plan ☐Yes ☐No
If Yes, Indicate Carrier _____
Name of Policyholder: _____
Individual Contract: ☐ Family Contract: ☐

2. On the effective date of this contract have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
DENTAL Plan ☐Yes ☐No
If Yes, Indicate Carrier _____
Name of Policyholder: _____
Individual Contract: ☐ Family Contract: ☐

3. On the effective date of this contract have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
VISION Plan ☐Yes ☐No
If Yes, Indicate Carrier _____
Name of Policyholder: _____
Individual Contract: ☐ Family Contract: ☐

COVERAGE ☐INDIVIDUAL ☐2-PERSON ☐FAMILY	HEALTH PLAN	DRUG PLAN	DENTAL PLAN	VISION PLAN

The above information is true and correct to the best of my knowledge. If any information pertaining to this application changes, I will notify my employer immediately.

SIGNATURE X _____ DATE _____

TO BE COMPLETED BY GROUP

FT/PT _____ **SCHEDULED HOURS** _____ **HIRE DATE** _____ **EFFECTIVE DATE** _____

TERM DATE _____

OFFICE USE ONLY

1	4	7	10	GROUP LEADER SIGNATURE
2	5	8	11	DATE
3	6	9		

DO NOT WRITE IN THIS SPACE

DATE RECEIVED	USER ID.

GROUP NUMBER _____

EFFECTIVE DATE _____

Claim Forms also available on our website
www.ebsbenefitsolutions.com