



GROUP ENROLLMENT FORM

DO NOT USE - FOR INTERNAL USE ONLY

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association
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 # Subgroup # Class#
0 0 0 6 3 2 3 2

Employer Name
JAMESVILLE DEWITT CSD

Association/Chamber Name (if applicable)
COOPERATIVE HEALTH INSURANCE FUND

Group Administrator Signature/Date
X

Dental Group # Subgroup #

Subscriber Status:
Active Retired COBRA Cancelled

Please indicate reason for COBRA:
Left Employment/Retirement Death of Spouse
Divorce/Legal Separation Dependent Reached Max Age
Loss of Student Status Other

Effective Date COBRA Effective Date

Hire/Rehire Date Retired Effective Date

Was the employee subject to a waiting period before enrolling in your employer health plan? No Yes

If yes, what was the start date: and end date

2 - Subscriber Plan Selection

Department # Employee #

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

- Classic Blue (XH)
Classic Blue (BMN)

Please check coverage type and person(s) to be covered:
Medical single sub & spouse sub & dependent(s) family
Dental 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 Domestic Partner
Open Enrollment Address/Phone Number Last Name Age 65+ Remove Dependent Change in Student Status
Medicare Eligible / Please indicate reason for Medicare eligibility: Newborn Disability End Stage Renal Disease
Add Dependent / Please indicate reason for adding dependent: Adoption Marriage Marital Status Change

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

MI 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 Social Security Number\*

Marital Status: Single Married Legally Separated Divorced/ Marital Status Event Date



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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 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?  No  Yes If yes, please indicate college/university name:  
College/University Name  Expected Graduation Date  Credit hours

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

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  
Is Dependent a full time student?  No  Yes If yes, please indicate college/university name:  
College/University Name  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	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

#### To Cancel a Dependent using the Group Enrollment Form:

- 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	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	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 four 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 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.

**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:

[www.excellusbcbs.com/cnycoop](http://www.excellusbcbs.com/cnycoop)