Excellus

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

Non-Monroe County Municipal School District Program (NMCMSDP) GROUP ENROLLMENT FORM

DO NOT USE – FOR INTERNAL USE ONLY

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# ☐☐☐☐

Employer Name

Group Administrator Signature/Date

X

Dental Group # ☐☐☐☐☐☐ Subgroup # ☐☐☐

Subscriber Status:
☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:
☐ Left Employ/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).

BluePoint2 $5/$10

☐ $5/$15/$30 RX (EB)
☐ $5/$20/$35 RX (EC)
☐ $10/$25/$40 RX (ED)

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ 2 person ☐ Family no spouse ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

BluePoint2 $15/$15

☐ $5/$15/$30 RX (EF)
☐ $5/$20/$35 RX (EG)
☐ $10/$25/$40 RX (EH)
☐ $0/$30/$50 RX (EI)

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ 2 person ☐ Family no spouse ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

BluePoint2 $20/$20

☐ $5/$15/$30 RX (EJ)
☐ $5/$20/$35 RX (ES)
☐ $10/$25/$40 RX (ET)

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ 2 person ☐ Family no spouse ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

Healthy Blue Copay

☐ $15 PCP/$25 Specialist (A1)
☐ $25 PCP/$40 Specialist (A2)
☐ $30 PCP/$50 Specialist (A3)

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

Healthy Blue Copay/Deductible

☐ $15 PCP/$25 Specialist Copay w/ $500 S/$1500 F Deductible (B1)

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

Healthy Blue HDHP

☐ $1,300 S/$2,600 F (C1) with 20% coinsurance

Dental (DE)
☐ Smile Saver I
☐ Smile Saver IV
☐ Modified Smile Saver IV

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family
Dental: ☐ single ☐ 2 person ☐ Family no spouse ☐ family

3 – Reason for Enrollment/Change

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

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐ Change in Student Status

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

☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Age 65+ ☐ Disability ☐ End Stage Renal Disease

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

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)* | Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)* | Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

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

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

Have you ever been a member of Excellus BlueCross BlueShield? ☐ No ☐ Yes

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 Last Name

Spouse First Name M.I.

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)*

Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

☐ Male ☐ Female Date of Birth

Social Security Number ___-___-____

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Subscriber's Last Name

Subscriber's First Name

Dependent's Last Name

Dependent's First Name M.I.

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)*

Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

☐ Male ☐ Female Date of Birth

Social Security Number ___-___-____

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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

College/University Name

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 | M.I.

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)* | Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)* | Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

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

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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

College/University Name | Expected Graduation Date | Credit hours

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

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)* | Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)* | Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

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

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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

College/University Name | Expected Graduation Date | Credit hours

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

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)* | Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)* | Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

☐ Male ☐ Female Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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

College/University Name | Expected Graduation Date | Credit hours

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

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)*

Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

☐ Male ☐ Female Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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

College/University Name | Expected Graduation Date | Credit hours

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

Primary Care Physician's Last Name *(To be completed by BluePoint applicants only.)*

Primary Care Physician's First Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's Last Name *(To be completed by BluePoint applicants only.)*

Ob/Gyn's First Name *(To be completed by BluePoint applicants only.)*

Are you a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

Are you a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ☐ No ☐ Yes

☐ Male ☐ Female Date of Birth Social Security Number Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

This section should only be completed for a dependent if enrolling in a dental coverage that includes a 19/23 dependent age rider.

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
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, 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
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.

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.
- POINT OF SERVICE (POS)
  I understand that the Point of Service (POS) coverage is comprised of the HMO in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provides the highest level of coverage under the plan.
- 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.

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 Customer Service at:

1-800-499-1275

Or, visit us at:

www.excellusbcbs.com/nonmonroeschools