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

Finger Lakes Area School Health Plan (FLASHP) GROUP ENROLLMENT FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#________________________________
EC__________________________________

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 # 00044311 Subgroup # 0001 Class# ____________

Employer Name: North Rose - Wolcott CSD

Group Administrator Signature/Date

Dental Group # _______________ Subgroup # _________ PKG# _________

SubscriberName:____________________________

Subscriber Status:
___ Active ___ Retired ___ COBRA ___ Cancelled

Please indicate reason for COBRA:
____ Left Employ/Retirement ____ Death of Spouse
___ Divorce/Legal Separation ____ Child 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? __X__ 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/$20/$35 RX (EC)

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/$20/$35 RX (EG)

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)
☐ $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

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

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.

Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? 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:	

Subscriber ID Number: ________________________Effective Date: ______________ Termination Date: ________________________

Subscriber Name:________________________________

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listed on Instruction Page).

Subscriber ___ Medical / Reason____ Date ______________________

___ Dental / Reason____ Date ______________________

Dependent (list each dependent in section 7) _____ Medical / Reason ____________________ Date ______________________

_____ Dental / Reason ___________________ Date ______________________

7 – Dependent Information

Please provide all information for each person to be covered.

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.)* ________________________

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

_____ 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. ____

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.)* ________________________

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* _____ No _____ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* _____ No _____ Yes

_____ Male Date of Birth Social Security Number

_____ Female ______________________ ____________-_______-_______________

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.

Subscriber Signature____**Date**________________________

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Finger Lakes Area School Health Plan
FLASHP
GROUP ENROLLMENT FORM

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

Subscriber Name:_________________________________

9 – Additional Dependents **PLEASE PRINT CLEARLY**

Please provide all information for each person to be covered.

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.)* ______________

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ____ No ____ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ____ No ____ Yes

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

___ Female ____________________ _________-______-_________ (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 ________

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.)* ______________

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ___ No ____ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ___ No ____ Yes

___ 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. ____

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.)* ______________

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ____ No ____ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ____ No ____ Yes

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

___ Female ____________________ _________-______-_________ (See last page for additional information) ____ No

Subscriber Name:___________________________________

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

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.)*

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

___ Male Date of Birth | Social Security Number | Is your over-age dependent handicapped or disabled? _____ Yes

___ Female _____________________ | __________-______-___________ | (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

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.)*

Is Dependent a Previous Patient of PCP? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

Is Dependent a Previous Patient of Ob/Gyn? *(To be completed by BluePoint applicants only.)* ___ No ___ Yes

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

___ Female _____________________ | __________-_______-___________ | (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

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 complete the 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 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) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.
- **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