Excellus

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

Inclusion through Diversity

TOMPKINS COUNTY

GROUP ENROLLMENT FORM

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 #
00036755

Subgroup #

Class#

Employer Name
Tompkins County

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).

Note on plan eligibility: All participants may elect the Platinum plan, but it is the **sole option** for the following participants:

> White Collar/Mgmt/Confidential/Elected Officials Hired On/After **08/18/15**

> Corrections Employees Hired On/After **09/05/17**

> Sheriff's Association Employees Hired On/After **02/04/16**

> Blue Collar Employees

> Retirees who opted into the Platinum previously

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

☐ Platinum ☐ Individual ☐ Family
☐ PPO
☐ Classic Blue

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

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

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

If answering "Yes", are you keeping the additional health coverage? ☐ No ☐ Yes

If you are keeping the other coverage and need to coordinate benefits, please answer the questions below:

Who does 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[/Domestic Partner] Last Name Spouse[/Domestic Partner] First Name M.I.

☐ Male Date of Birth Social Security Number Are you enrolling as a Domestic Partner?

☐ Female - - ☐ Yes ☐ No

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

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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

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**_____

Dependent Eligibility Verification Requirements:

> If you are enrolling a **Spouse** or **Domestic Partner** to coverage, you must attach to your application a copy of your **Marriage Certificate** or **Certificate of Domestic Partnership**.

> If you are enrolling any **Dependent Children** (including Step Children, Children of a Domestic Partner, or any children over whom you have custody), you must attach to your application copies of **birth certificate(s)** and copies of adoption paperwork or court order of custody (if applicable).

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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.

☐ 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)

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 Eligibility Verification Requirements:

> If you are enrolling a **Spouse** or **Domestic Partner** to coverage, you must attach to your application a copy of your **Marriage Certificate** or **Certificate of Domestic Partnership**.

> If you are enrolling any **Dependent Children** (including Step Children, Children of a Domestic Partner, or any children over whom you have custody), you must attach to your application copies of birth certificate(s) and copies of adoption paperwork or court order of custody (if applicable).

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, 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
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 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.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical 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.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical) 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