



BlueCross BlueShield of Western New York

A Division of HealthNew New York Inc. An Independent Licensee of the BlueCross BlueShield Association



PO Box 80, Buffalo, NY 14240-0080

1—Group Employer Information

Enrollment Application/Change Form

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 # boxes

Employer Name box

Association/Chamber Name (if applicable) box

Group Administrator Signature / Date box

Subscriber Status:

Active, Retired, COBRA radio buttons

Please indicate reason for COBRA:

Left Employ / Retirement, Divorce/Legal Separation, Loss of Student Status, Death of Spouse, Dependent Reached Max Age, Other radio buttons

Effective Date (MMDDYY)

Effective Date boxes

COBRA Effective Date (MMDDYY)

COBRA Effective Date boxes

Hire/Rehire Date (MMDDYY)

Hire/Rehire Date boxes

Retired Effective Date (MMDDYY)

Retired Effective Date boxes

2—Subscriber Plan Section

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

Plan Number, PCP \$, Specialist \$ boxes

Plan selection radio buttons: POS, POS Plus, Dental, HMO, HMO Plus, PPO, Traditional, Vision, EPO, Aqua, Other, and coverage type options

3—Reason for Enrollment/Change

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

Reason for enrollment radio buttons: New Hire, Open Enrollment, Add Dependent, COBRA, Address/Phone Number, Last Name, Primary Care Physician, Last Name, Remove Dependent, Retirement, Marriage, Loss of Coverage, Adoption, Domestic Partner, Change in Student Status

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, First Name, M.I. boxes

Social Security Number, Date of Birth, Telephone Number, Gender radio buttons

Mailing Address, Apt/Suite, Marital Status radio buttons

City, State, Zip Code, Legally Separated, Widowed radio buttons

E-mail Address, Marital Status Event Date (MMDDYY) boxes

Medicare Eligible radio buttons: Age 65+, Disability, End Stage Renal Disease

Medicare Number, Part A, B, D Effective Date (MMDDYY) boxes



4—Subscriber Information continued

Primary Care Physician's Last Name Primary Care Physician's First Name

Primary Care Physician Number Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No

Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)

5—Dependent Information Please provide all information for each person to be covered.

Spouse/Domestic Partner's Last Name Spouse/Domestic Partner's First Name M.I.

Social Security Number - - Date of Birth (MMDDYY) Male Female Are you enrolling as a Domestic Partner? Yes No

E-mail Address

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

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

Primary Care Physician's Last Name Primary Care Physician's First Name

Primary Care Physician Number Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No

Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)

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

Social Security Number - - Date of Birth (MMDDYY) Male Female Is your over-age dependent handicapped? (See instructions for additional information) Yes No

E-mail Address

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

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

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

College/University Name Expected Graduation Date (MMDDYY)

Primary Care Physician's Last Name Primary Care Physician's First Name

Primary Care Physician Number Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No

Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)



Additional Dependents
Enrollment Application/Change Form

5—Dependent Information continued

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name M.I.

Social Security Number - - Date of Birth (MMDDYY)

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

Social Security Number - - Date of Birth (MMDDYY) Male Female
Is your over-age dependent handicapped? Yes No
(See instructions for additional information)

E-mail Address

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

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

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

College/University Name Expected Graduation Date (MMDDYY)

Primary Care Physician's Last Name Primary Care Physician's First Name

Primary Care Physician Number Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No

Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)

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

Social Security Number - - Date of Birth (MMDDYY) Male Female
Is your over-age dependent handicapped? Yes No
(See instructions for additional information)

E-mail Address

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

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

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

College/University Name Expected Graduation Date (MMDDYY)

Primary Care Physician's Last Name Primary Care Physician's First Name

Primary Care Physician Number Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes No

Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No

Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)

5—Dependent Information continued

Please provide all information for each person to be covered.

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Male

Is your over-age dependent handicapped?

Yes

Female

(See instructions for additional information)

No

E-mail Address

Medicare Eligible Please indicate reason for Medicare eligibility:

Age 65+

Disability

End Stage Renal Disease

Medicare Number (if applicable)

Part A Effective Date (MMDDYY)

Part B Effective Date (MMDDYY)

Part D Effective Date (MMDDYY)

Is dependent a full-time student?

Yes

No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date (MMDDYY)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number (see directory)

Are you a current patient, or if not a current patient, have

you verified that the PCP will accept you as a new patient?

Yes

No

Name of Prior Health Care Insurer

Do you have additional group health insurance?

Yes

No

Policy Identification Number

Policy Effective Date (MMDDYY)

Policy Cancellation Date (MMDDYY)

HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and;
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Traditional Coverage

- If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective date of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
- We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.

6—Disclosure / Signature

Subscriber signature required.

Important: Please read and sign below:

*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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.



Subscriber Signature

Date