

**Underwriting Requirements for Employer Groups enrolling in a Chamber of Commerce  
Association Group with BlueCross BlueShield of WNY**

- \_\_\_\_\_ 1. Completed Applications
  
- \_\_\_\_\_ 2. BlueCross BlueShield of WNY Group Enrollment Form for Employer Groups
  
- \_\_\_\_\_ 3. Company Tax Documentation (NYS45-ATT or Partnership K-1's)
  
- \_\_\_\_\_ 4. Check for the first month's premium, made payable to Bene-Care



**5 – Dependent Information**

Please provide all information for each person to be covered.

Spouse/Domestic Partner Last Name

[Grid for Spouse/Domestic Partner Last Name]

Spouse/Domestic Partner First Name

[Grid for Spouse/Domestic Partner First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth: MMDDYY]

Male

Female

Are you enrolling as a Domestic Partner?

Yes  No

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date

[Grid for Part A Effective Date: MMDDYY]

Part B Effective Date

[Grid for Part B Effective Date: MMDDYY]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?

Yes

No

Dependent's Last Name

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth: MMDDYY]

Male

Female

Is your over-age dependent handicapped? (See instructions for additional information)

Yes

No

Are you a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

[Grid for College/University Name]

Expected Graduation Date

[Grid for Expected Graduation Date: MMDDYY]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?

Yes

No

Dependent's Last Name

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth: MMDDYY]

Male

Female

Is your over-age dependent handicapped? (See instructions for additional information)

Yes

No

Are you a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

[Grid for College/University Name]

Expected Graduation Date

[Grid for Expected Graduation Date: MMDDYY]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for Primary Care Physician Number]

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?

Yes

No

**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.

**X** Subscriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Additional Dependents Enrollment Application/Change Form

### 7- Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name	Subscriber's First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number

Dependent's Last Name	Dependent's First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number

Date of Birth

Male    Is your over-age dependent handicapped?  Yes  
 Female    (See instructions for additional information)  No

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

College/University Name	Expected Graduation Date
<input type="text"/>	<input type="text"/>

Primary Care Physician's Last Name	Primary Care Physician's First Name
<input type="text"/>	<input type="text"/>

Primary Care Physician Number

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?  Yes  No

Dependent's Last Name	Dependent's First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number

Date of Birth

Male    Is your over-age dependent handicapped?  Yes  
 Female    (See instructions for additional information)  No

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

College/University Name	Expected Graduation Date
<input type="text"/>	<input type="text"/>

Primary Care Physician's Last Name	Primary Care Physician's First Name
<input type="text"/>	<input type="text"/>

Primary Care Physician Number (see directory)

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?  Yes  No

Dependent's Last Name	Dependent's First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number

Date of Birth

Male    Is your over-age dependent handicapped?  Yes  
 Female    (See instructions for additional information)  No

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

College/University Name	Expected Graduation Date
<input type="text"/>	<input type="text"/>

Primary Care Physician's Last Name	Primary Care Physician's First Name
<input type="text"/>	<input type="text"/>

Primary Care Physician Number (see directory)

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients?  Yes  No



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

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

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

College/University Name  Expected Graduation Date

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

Primary Care Physician Number  If the dependent is not a current patient, have you verified that the PCP is accepting new patients?  Yes  No

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

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

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

College/University Name  Expected Graduation Date

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

Primary Care Physician Number  If the dependent is not a current patient, have you verified that the PCP is accepting new patients?  Yes  No

**HMO/POS Coverage**

- If you chose HMO or POS coverage, you are entitled to direct access to care from any participating OB/GYN provider without obtaining a referral. Other medical care should be coordinated by your Primary Care Physician (PCP) whom you have chosen and listed on this application.
- Our contracts provide the following benefits:
- Coverage for hospital stay for members who have undergone a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer.
- Following a mastectomy, coverage for breast reconstruction on the affected breast and the other breast necessary to produce a "symmetrical" appearance.
- Coverage for second medical opinion following any positive or negative treatment of cancer.

**Traditional Indemnity 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.

Chamber/Association/Payroll Administrator Name \_\_\_\_\_

Employer Group Name \_\_\_\_\_

Employer Physical Address \_\_\_\_\_

Employer Mailing Address \_\_\_\_\_

Employer Telephone \_\_\_\_\_ Contact Person \_\_\_\_\_

Employer Federal ID No. \_\_\_\_\_ Member of Chamber/Association since \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**The following requirements apply to small groups:** The purpose of this documentation is to assure the group has a legitimate existence, and was not formed solely for the purpose of seeking insurance.

**To be eligible for enrollment as a small group,** the following requirements must be met. The applicant must:

1. Submit their **most recent NYS-45-ATT** to show they are an active business.
2. If a NYS-45-ATT is not available due to a group being newly formed, then the NYS-45-ATT must be provided within 90 days of the effective date of coverage. If such documentation is not provided, the group will be terminated on the 90<sup>th</sup> day,
3. **New groups who have been members of the chamber for 30 days can be set up at any time during the year. Existing members of the chamber can be set up at Open Enrollment.** The appropriate documentation must be attached to this submission. All paperwork, including applications, must be received by the **15<sup>th</sup> of the month** prior to the effective date.

**Groups with NYS-45 ATT - please check all appropriate boxes**

- I am enclosing the most recent NYS-45 ATT for my business.
- All of my covered employees are listed on the NYS-45 ATT.
- These newly hired employees will be listed on my next NYS-45 ATT. I am enclosing copies of these employees' 2 most recent paystubs.

Name \_\_\_\_\_ Name \_\_\_\_\_

- One or more of my covered employees are not listed on the NYS-45 ATT. If retired or on COBRA enter the month and year of retirement or COBRA. Enclosed is a copy of the last NYS-45 ATT on which the retiree or employee on COBRA appeared. Please list owners name(s) not appearing on the NYS-45 ATT and submit the appropriate IRS schedule listed below.

Name \_\_\_\_\_ Reason \_\_\_\_\_

Name \_\_\_\_\_ Reason \_\_\_\_\_

**Partners/Owners/Businesses not on NYS-45 ATT - please check all appropriate boxes**

- As a partnership/S Corp, I am enclosing an IRS Schedule C or K for the most recently filed tax year
- As a partnership/S Corp, I certify I work at least 20 hours per week
- As a Farmer, I am enclosing an IRS Schedule F for the most recently filed tax year
- As a Farmer, I certify I work at least 20 hours per week

**By signing below the employer group certifies that they meet the eligibility requirements to be enrolled.** I certify that the above information is true and accurate to the best of my knowledge. I understand that enrollment is subject to **BlueCross BlueShield of Western New York** underwriting guidelines and the Group Health Care contract between the Chamber/Association and **BlueCross BlueShield**. I understand that **BlueCross BlueShield** will conduct annual audits to ensure compliance with these guidelines, which may require us to provide verification of our being a legitimate employer group.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date