

Underwriting Requirements for Employer Groups enrolling in the Bene-Care

BlueCross BlueShield of WNY Association Group

- _____ 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



Community Blue • Traditional Blue

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

PO Box 80, Buffalo, NY 14240-0080



Enrollment Application/Change Form

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 # boxes

Employer Name box

Association/Chamber Name (if applicable) box

Group Administrator Signature / Date box with 'X' mark

Subscriber Status:

Active, Retired, COBRA radio buttons

Please indicate reason for COBRA:

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

Effective Date MMDDYY box

COBRA Effective Date MMDDYY box

Hire/Rehire Date MMDDYY box

Retired Effective Date MMDDYY box

2 - Subscriber Plan Selection

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

Traditional Blue Plan Number, Community Blue Plan Number, POS, EPO, Dental, HMO, HMO Plus, PPO, Traditional, Vision, Other radio buttons

Please indicate HMO or HMO Plus copay: PCP, Specialist, \$ boxes

Please choose coverage type Single or Family: Medical, Dental, Vision, S, F radio buttons

3 - Reason for Enrollment/Change

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

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

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, M.I., Male, Female radio buttons

Social Security Number, Date of Birth MMDDYY, Telephone Number (include area code) boxes

Marital Status:

Single, Married, Legally Separated, Divorced, Widowed radio buttons

Mailing Address, Apt or Suite boxes

City, State, Zip Code boxes

Medicare Number (if applicable), Part A Effective Date MMDDYY, Part B Effective Date MMDDYY, Marital Status Event Date MMDDYY boxes

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

Primary Care Physician Number (see directory) box

If you are not a current patient, have you verified that your PCP is accepting new patients? Yes No radio buttons

Do you, your spouse or any enrolled dependents have additional health coverage? Yes No radio buttons



5 – Dependent Information

Please provide all information for each person to be covered.

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

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

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

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.

Social Security Number

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

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

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

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

Is dependent 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 (see directory) If the dependent is not a current patient, have you verified that the PCP is accepting new patients? Yes No



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 90th 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 15th 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 _____