

2010 Underwriting Requirements for GRAR Members through  
Excellus BlueCross BlueShield

- \_\_\_ 1. Professional Society & Association Member Information Form
- \_\_\_ 2. Attestation
- \_\_\_ 3. Completed Excellus BC/BS Enrollment Form
- \_\_\_ 4. Copy of Realtor's License (must still be valid)
- \_\_\_ 5. Schedule C or Form 1099 (from 2008 or 2009)
- \_\_\_ 6. Proof of Greater Rochester Association of Realtors Membership
- \_\_\_ 7. Check for the first month's premium made payable to Bene-Care
- \_\_\_ 8. Proof of a Qualifying Event if enrolling outside of Open Enrollment

**Professional Society and Association Member Information**

(Must be completed for each Association Member enrolling in  
Excellus Health Plan, Inc. health insurance through the Sponsor Organization)

1. Name and Address of Association Member. \_\_\_\_\_

2. Name, Title and Phone # of Contact Person at Association Member.

\_\_\_\_\_ ( ) - \_\_\_\_\_  
Name Title Telephone

3. Desired effective date of health insurance coverage. \_\_\_\_\_

4. The Association Member will enroll as an Employer Group OR as an Individual Member. Check which applies, A or B.

A. \_\_\_\_\_ Employer Group Enrollment Questions—If you are seeking coverage for employees of your firm, practice or other business entity, provide the following information:

\_\_\_\_\_ (1) Total number of individuals actively working at firm, practice, etc. (not retirees)\*

\_\_\_\_\_ (2) Total number of retirees eligible for coverage (if any)\*

\_\_\_\_\_ (3) Number of employees NOT eligible for coverage (less than 20 hours per week, etc.)

\_\_\_\_\_ (4) Number of eligible employees NOT taking coverage due to coverage elsewhere (such as coverage through a spouse)

\_\_\_\_\_ (5) SUM TOTAL-number of employees and retirees who are eligible to select coverage through this group, excluding the number in "4" above who have coverage elsewhere (5=1+2-3-4)

\_\_\_\_\_ (6) Number of eligible employees and retirees selecting no coverage AT ALL

\_\_\_\_\_ (7) NET number of eligible individuals taking coverage through this firm, practice, etc. whether the coverage is issued by Excellus or by another insurer or HMO (5=6+7)

\*Include employees and other individuals working a minimum of 20 hours per week (unless the employer's eligibility rules require a greater number of hours per week); retirees when the consistent policy of the business is to cover retirees; and owners of the business if actively engaged in the business but not technically an employee. **Attach supporting documentation. See reverse side.**

B. \_\_\_\_\_ Individual Member Enrollment Questions—If you are seeking coverage for yourself (including your spouse and dependent children), provide the following information:

(1) The date you became a member of the Association \_\_\_\_\_

(2) If the date in "1" above is more than 30 days prior to the current date, the reason you did not apply for coverage when you initially became a member of the Association \_\_\_\_\_

(3) If the reason in "2" above is that you had coverage under another plan and coverage under that plan terminated, the date of termination of coverage \_\_\_\_\_

5. Signature. The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including, when applicable, the number of persons proposed for coverage who work at least 20 hours per week.

\_\_\_\_\_  
Signature of Contact Person Date Fax Number or E-Mail Address

**For Society/Association Use Only.**

The above is a current Member of \_\_\_\_\_  
(Professional Society or Association)

\_\_\_\_\_  
Society/Association Contact Person Signature (Date) Fax Number or E-Mail Address

Professional Society or Association to provide the unique identifying Alpha/Numeric indicator assigned by Society/Association to the Member and all related employees covered under this Excellus Health Insurance Plan: \_\_\_\_\_

In support of the information provided in #4.A. on the reverse side, attach the following supporting documentation that the employees or eligible retirees were not added to the Association Member solely to obtain insurance:

1. All businesses requesting employee coverage must provide a copy of the most recent NYS-45-ATT-MN, with notations indicating eligible employees (those working a minimum of 20 hours per week) and ineligible employees (part-time employees working fewer than 20 hours per week, seasonal employees and other persons not eligible for health insurance). NOTE: If the Association Member's rules require a minimum of more than 20 hours per week in order to be eligible for coverage, e.g., 30 hours, then the notations should be based on the Association Member's own eligibility rule.
2. If there are any persons who are proposed for health insurance WHO ARE NOT listed on the NYS-45-ATT-MN, the business must provide an attestation that the individuals not listed on the NYS-45-ATT-MN work at least 20 hours per week or are otherwise eligible for coverage (e.g., retired, partner, business owner).





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

SimplyBlue
GROUP ENROLLMENT FORM

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.

Group #, Subgroup #, Class#, Employer Name, Association/Chamber Name, Group Administrator Signature/Date

Subscriber Status: Active, Retired, COBRA, Cancelled
Please indicate reason for COBRA: Left Employment/Retirement, Death of Spouse, Divorce/Legal Separation, Dependent Reached Max Age, Loss of Student Status, Other
Effective Date, COBRA Effective Date

X

Dental Group #, Subgroup #, Hire/Rehire Date, Retired Effective Date

Was the employee subject to a waiting period before enrolling in your employer health plan? 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).

Copay Options, Copay & Deductible Option, HDHP Options, Please check coverage type and person(s) to be covered: Medical, Dental, Dental Blue Classic (DI), Dental Blue Options (DJ)

3 - Reason for Enrollment/Change

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

New Hire, Open Enrollment, Medicare Eligible, Add Dependent, COBRA, Address/Phone Number, Last Name, Remove Dependent, Change in Student Status, Disability, End Stage Renal Disease, Marriage, Loss of Coverage, Adoption, Domestic Partner

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, Middle Initial, Title, E-mail Address, Mailing Address, City, State, Zip, Work Phone Number, Home Phone Number, Cell Phone Number, Subscriber's First Name





SimplyBlue GROUP ENROLLMENT FORM

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

PLEASE PRINT CLEARLY

9 - Additional Dependents

Please provide all information for each person to be covered.

Form for the first dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the second dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the third dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the fourth dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

Form for the fifth dependent, including fields for Last Name, First Name, M.I., Date of Birth, Social Security Number, and student status.

## 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 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 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	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 members 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 dependent age for your employer group:
  - Unmarried child, natural, adopted or stepchild
  - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.
  - Dependents pending adoption and/or a handicapped 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.
- **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.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

**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 your Group Administrator/Representative.

[www.excellusbcb.com](http://www.excellusbcb.com)



HealthyBlue GROUP ENROLLMENT FORM

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

Instructions on Back. All Dates = mm/dd/yy Check if name change Check if new address

PLEASE PRINT CLEARLY

Form section for selecting a medical or dental plan and checking desired actions like adding subscribers or dependents.

SUBSCRIBER INFORMATION - Must be completed. Includes fields for Social Security #, Sex, Date of Birth, Last Name, First Name, Street, City, State, Zip, Day Phone, Email Address, and Medicare status.

FAMILY MEMBER INFORMATION. Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled. Includes fields for Last Name, First Name, Social Security #, Sex, and Date of Birth for multiple family members.

OTHER COVERAGE INFORMATION. In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer. Includes questions about other insurance and Medicare.

RELEASE - 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...

EMPLOYER INFORMATION (Must be completed by Group Administrator/Representative) \* Dept. # and Employee # is optional. Was the employee subject to a waiting period before enrolling in your employer health plan?

Table with columns: Coverage, Group/Sub Group #, Check digit, Pkg #, Employer Name, Employee Status, Department #, Employee #.

Group Rep Signature/Date:

A Group Enrollment Form is not required for a change of address or correction to a date of birth. Please contact Customer Service at the number listed on your member ID card.

**DESIRED ACTION** Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of 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 Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

**Cancel Request**

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

**To Cancel an Employee/Subscriber using the Group Enrollment Form:**

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

**Cancel Subscriber Reasons**

LE - Left Employer/No Longer Eligible	CE – Cobra End Date
PC -- Preferred Care	SR – Subscriber Request
CP -- Commercial	SD – Subscriber Deceased
CB -- Cobra Begin Date	SB – Spouse's Excellus BCBS
CD -- Cobra Disabled Date	MC – Medicaid

**To Cancel a Dependent using the Group Enrollment Form:**

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

**Cancel Dependent Reasons**

MA – Marriage	MB – COBRA Begin Date
OA – Dependent Over Age	MR – Subscriber Request
DM – Deceased	DV – Divorce

**DESIRED COVERAGE** 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 five members 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 dependent age for your employer group:
  - Unmarried child, natural, adopted or stepchild
  - Chiefly dependent on you for support
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

**Dependents pending adoption, foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a handicapped 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.
- **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.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

**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 your Group Administrator/Representative.**

**Or, visit us at: [www.excellusbcbs.com](http://www.excellusbcbs.com)**



GROUP ENROLLMENT FORM

165 Court Street, Rochester, NY 14647
A nonprofit independent licensee of the BlueCross BlueShield Association

Excensus Use Only - Do Not Write in this Space

Instructions on Back. All Dates = mm/dd/yy [ ] Check if name change [ ] Check if new address Please print clearly.

Check desired action: Add Subscriber (AA), Add Dependent (AB), Change Coverage (AC), Transfer to COBRA (AD), Cancel Subscriber (S), Cancel Dependent (M).
Check desired medical/dental/vision coverage: Blue Choice BC, Blue Choice Select BS, Blue Choice Plus BY, Blue Choice Value BV, Blue Choice Essential CE, Blue Choice POS BP, Blue Choice 25 BZ, BluePoint 2 SF, Blue Choice Freedom BF, BCBS Comprehensive CO, Blue Choice Preference, Healthy Choices HH, Family First FF, PPO PN, Blue PPO BP, Blue EPO BE, BluePPO Savings Account Plan DC, Blue EPO Balance UE, FourFront EF, BluePPO/HSA HF, Comprehensive Plus CP, BCBS Traditional TR.
Check person(s) covered: Self, Spouse & Child(ren) (A), Self & Child(ren) (B), Self & Spouse (C), Self (D).

Subscriber Information - Must be completed. Social Security #, Sex, Birthdate, Last Name, First, Street, City, State, Zip, Day Phone, E-Mail Address.
Check Medical Center: (W)ilson, (F)olsom, (G)reece, (P)erinton. Current Patient? Primary Provider (Last, First), OB/GYN Provider (Last, First).

Family Member Information - Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.
(S)pouse, (D)ependent, Student(T), (H)disabled, (F)oster/Grandchild Dependent, Other. Social Security #, Sex, Birthdate, Medical Center, Primary Care Physician, Current patient?, OB/GYN Physician.

Other Coverage Information - Must be completed. You may be contacted for additional information.
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.
Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
Check previous insurance company from list below and indicate ID #: (B) Excensus BlueCross BlueShield, Rochester Region, Blue Choice, ViaHealth Plan. (O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name: (C) Other Carrier - Indicate Plan Name:

RELEASE - 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 \_\_\_\_\_

EMPLOYER INFORMATION (Must be completed by Group Administrator) \*\*\*Deductible Amt., Dept. # and Employee # is optional.

Was the employee subject to a waiting period before enrolling in your employer health plan? [ ] Yes [ ] No
If yes, what was the start date \_\_\_/\_\_\_/\_\_\_ and end date \_\_\_/\_\_\_/\_\_\_

Table with columns: Coverage, Group/Sub Group #, Chk digit, Pkg #, Deductible Amount\*\*\*, Employer Name. Rows for Medical, Dental, Vision.

## Instructions for completing the Group Enrollment Form

**DESIRED ACTION** Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of 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 60 days of the Event Date. Please see your Group Administrator for events that fall outside the 60-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

### Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

#### To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber (S) Box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible	CE - Cobra End Date
PC - Preferred Care	SR - Subscriber Request
CP - Commercial	SD - Subscriber Deceased
CB - Cobra Begin Date	SB - Spouse's BCBSRA
CD - Cobra Disabled Date	MC - Medicaid

#### To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental, Vision)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

#### Cancel Dependent Reasons

MA - Marriage	MB - COBRA Begin Date
OA - Dependent Over Age	MR - Subscriber Request
DM - Deceased	DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- Address
- Birthdate
- PCP
- OB/GYN
- Medical Center

**DESIRED COVERAGE** All products may not be applicable to your employer group. Please check with your Group Administrator.

#### [ PCP Information

Blue Choice members must select a **Medical Center OR Primary Care Physician (PCP)**. Females may select an OB/GYN.

\*ViaHealth Plan members **should not** select a Medical Center.

\*\*Finger Lakes members have the option to list a Primary Care Physician (PCP) and OB/GYN. Members **should not** select a Medical Center. ]

#### FAMILY MEMBER AND DOCTOR INFORMATION

Use an additional form, if more than four persons.

##### QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
  - A resident in the subscriber's household or the household of an ex-spouse
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.**  
Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

#### RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.
- **BLUE CHOICE**  
I understand that if I have elected a managed care product, that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.
- **POINT OF SERVICE (POS) – Blue Choice POS (BP) & Blue Choice Plus (BY)**  
I understand that the Point of Service (POS) coverage is comprised of the HMO in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provided the highest level of coverage.
- **PREFERRED PROVIDER ORGANIZATION (PPO) & (EPO)**  
I understand that the Preferred Provider Organization (PPO) coverage is comprised of and 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.

#### EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Administrator.  
Complete only the coverage section (Medical/Dental/Vision) that is applicable to the employee's request.

**If you have any questions, please contact Customer Service at:**  
**Excellus BlueCross BlueShield, Rochester Region (585) 325-3630 or 1-800-847-1200**  
**Blue Choice Member Services (585) 454-4810 or 1-800-462-0108**