BlueCross BlueShield of Western New York

Community Blue • Traditional Blue

A Division of HealthNow 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 #

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

X

Subscriber Status:

◯ Active ◯ Retired ◯ COBRA

Please indicate reason for COBRA:

◯ Left Employ / Retirement ◯ Death of Spouse

◯ Divorce/Legal Separation ◯ Dependent Reached Max Age

◯ Loss of student status ◯ Other

Effective Date M M D D Y Y

COBRA Effective Date M M D D Y Y

Hire/Rehire Date M M D D Y Y

Retired Effective Date M M D D Y Y

2 – Subscriber Plan Selection

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

Traditional Blue Plan Number:

◯ POS ◯ EPO ◯ Dental

◯ PPO ◯ Traditional ◯ Vision

Community Blue Plan Number:

◯ HMO ◯ HMO Plus

◯ Other

Please indicate HMO or HMO Plus copay:

PCP $

Specialist $

Please choose coverage type Single or Family :

◯ Medical ◯ S ◯ F

◯ Dental ◯ S ◯ F

◯ Vision ◯ S ◯ F

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

◯ Add Dependent Please indicate reason for adding dependent: ◯ Newborn ◯ 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

Subscriber's First Name

M.I.

◯ Male

◯ Female

Social Security Number

Date of Birth M M D D Y Y

Telephone Number (include area code)

Marital Status:

◯ Single

◯ Married

◯ Legally Separated

◯ Divorced

◯ Widowed

Mailing Address

Apt or Suite

City

State

Zip Code

Medicare Number (if applicable)

Part A Effective Date M M D D Y Y

Part B Effective Date M M D D Y Y

Marital Status Event Date M M D D Y Y

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number (see directory)

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

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

Form # CN9XAN0002

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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 M M D D Y Y

Male

Female

Are you enrolling as a Domestic Partner? Yes No

Medicare Number (if applicable)

Part A Effective Date M M D D Y Y

Part B Effective Date M M D D Y Y

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

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Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

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 M M D D Y Y

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

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Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

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 M M D D Y Y

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

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

College/University Name
Expected Graduation Date
M M D D Y Y

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

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

College/University Name
Expected Graduation Date
M M D D Y Y

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

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

College/University Name
Expected Graduation Date
M M D D Y Y

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 M M D D Y Y

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

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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 M M D D Y Y

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 M M D D Y Y

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.