



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 medical or dental plan and checking desired actions like 'Add Subscriber' or 'Change Coverage'.

SUBSCRIBER INFORMATION - Must be completed. Includes fields for Social Security #, Last Name, First Name, Street, City, State, Zip, Date of Birth, Sex, and Employment 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 coverage.

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). Includes fields for Coverage, Group/Sub Group #, Check digit, Pkg #, Employer Name, Employee Status, Department #, and Employee #.