Rochester Area Schools Health Plan 2 - Enrollment Form

Excellus

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

PLEASE PRINT CLEARLY District Name: monroe #1 Boces

Section 1: Subscriber Information

Subscriber ID *(if available)*:

Type of Transaction (Group Administrator, please indicate (√) transaction to be processed and applicable date(s)):

☐ Add Subscriber ☐ Add Family Member ☐ Change of Coverage ☐ Transfer to COBRA | COBRA Effective Date:

Date of Hire/Event: Coverage ~~Effective~~ Date: 7/1/12

Reason for Transaction (Subscriber, please indicate (√) the reason(s) for this enrollment, change or cancellation):

☐ New Hire/Active ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐ Domestic Partner/Same Sex ☐ Age 65+ ☐ Address/Phone#

☐ Open Enrollment ☐ Last Name Change ☐ Remove Family Member ☐ Disability ☐ Change in Student Status (*Dental Only*)

☐ Add Family Member | Reason: ☐ Newborn ☐ Marital Status Change ☐ Adoption ☒ Other: Cancel

Plan Selection (Subscriber, please select (√) one medical and/or one dental plan product, as applicable):

☐ Blue Point 2 Extended (EA) ☐ Blue Point 2 Select (EB) ☐ Blue Point 2 Value (EC) ☐ Dental (DE)

☐ SimplyBlue Hybrid: $30/$50 Copay - $250/$750 Ded (LO)

Type of Coverage (Subscriber, select (√) one option for the applicable medical and/or dental plan(s) selected above):

Medical: ☐ Single ☐ Family ☐ Sub & Spouse ☐ Sub & Child ☐ Family No Spouse

Dental: ☐ Single ☐ Family ☐ Sub & Spouse ☐ Sub & Child ☐ Family No Spouse

Subscriber's Last Name: **First Name:** **Middle Initial:**

Social Security #: ___ - ___ - ___ Date of Birth *(mm/dd/yyyy)*: ___/___/___ Gender: ☐M ☐F

Mailing Address: Apt or Suite:

City: State: Zip:

Home Phone Number: Work Phone Number:

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced | Marital Status Event Date:

Primary Care Physician's Last Name: First Name: Current Patient: ☐Y ☐N

OB/GYN's Last Name: First Name: Current Patient: ☐Y ☐N

Medicare Number *(If applicable)*:

Part A Effective Date: Part B Effective Date (*required if Medicare is primary*):

Section 2: Family Member Information

Please provide all applicable information for each family member to be covered/changed/cancelled.

Spouse's Last Name: **First Name:** **M.I.:**

Social Security #: ___ - ___ - ___ Date of Birth *(mm/dd/yyyy)*: ___/___/___ Gender: ☐M ☐F

Primary Care Physician's Last Name: First Name: Current Patient: ☐Y ☐N

OB/GYN's Last Name: First Name: Current Patient: ☐Y ☐N

Medicare Number *(If applicable)*:

Part A Effective Date: Part B Effective Date (*required if Medicare is primary*):

Family Member's Last Name: **First Name:** **M.I.:**

Social Security #: ___ - ___ - ___ Date of Birth *(mm/dd/yyyy)*: ___/___/___ Gender: ☐M ☐F

Primary Care Physician's Last Name: First Name: Current Patient: ☐Y ☐N

OB/GYN's Last Name: First Name: Current Patient: ☐Y ☐N

(*Dental Only*) Full Time Student? ☐N ☐Y | If yes, indicate College/University Name:

Expected Graduation date: Credit Hours:

Medicare Number *(If applicable)*:

Part A Effective Date: Part B Effective Date (*required if Medicare is primary*):

Subscriber's Last Name:

Family Member's Last Name:	First Name:	M.I:
Social Security #: ___ - ___ - ___	Date of Birth *(mm/dd/yyyy)*: ___/___/___	Gender: ☐M ☐F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐Y ☐N
OB/GYN's Last Name:	First Name:	Current Patient: ☐Y ☐N
(Dental Only) Full Time Student? ☐N ☐Y	If yes, indicate College/University Name:	
Expected Graduation date: ___	Credit Hours: ___	
Medicare Number *(If applicable)*: ___		
Part A Effective Date: ___	Part B Effective Date *(required if Medicare is primary)*: ___	

Family Member's Last Name:	First Name:	M.I:
Social Security #: ___ - ___ - ___	Date of Birth *(mm/dd/yyyy)*: ___/___/___	Gender: ☐M ☐F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐Y ☐N
OB/GYN's Last Name:	First Name:	Current Patient: ☐Y ☐N
(Dental Only) Full Time Student? ☐N ☐Y	If yes, indicate College/University Name:	
Expected Graduation date: ___	Credit Hours: ___	
Medicare Number *(If applicable)*: ___		
Part A Effective Date: ___	Part B Effective Date *(Required if Medicare is primary)*: ___	

Family Member's Last Name:	First Name:	M.I:
Social Security #: ___ - ___ - ___	Date of Birth *(mm/dd/yyyy)*: ___/___/___	Gender: ☐M ☐F
Primary Care Physician's Last Name:	First Name:	Current Patient: ☐Y ☐N
OB/GYN's Last Name:	First Name:	Current Patient: ☐Y ☐N
(Dental Only) Full Time Student? ☐N ☐Y	If yes, indicate College/University Name:	
Expected Graduation date: ___	Credit Hours: ___	
Medicare Number *(If applicable)*: ___		
Part A Effective Date: ___	Part B Effective Date *(Required if Medicare is primary)*: ___	

Section 3: Previous Coverage

Please provide other/previous coverage information as indicated in boxes below. *(Select (✓) all that apply)*:

Have you, or any enrolled family member had other coverage within the last 63 days?	Health? ☐N ☐Y	Dental? ☐N ☐Y
If answering "Yes", are you keeping the additional health and/or dental coverage?	Health? ☐N ☐Y	Dental? ☐N ☐Y

Who did *(does)* the other plan cover? ☐Self ☐Spouse ☐Child(ren)

Other insurance carrier name:	Other insurance name of policyholder:	
Policy ID #:	Effective Date: ___	Termination date: ___

Section 4: Subscriber Release

Subscriber signature required. 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 (see the "Instruction Page" at the end of this form).

Subscriber Signature ..... **Date** .....

Section 5: Group Employer Information

This form cannot be processed without the Information in this section and the signature of the Group Benefits Administrator.

Was the employee subject to a waiting period before enrolling in your employer health plan? ☐N ☐Y | If yes, what was the start date: ___ And the end date: ___

Medical Group#: 00044333 Subgroup#: 0601	Class#: A100	Department Code: ___
Dental Group#: 20638497 Subgroup#: ___	Pkg#: ___	

Group Administrator Signature ..... Mary Boyle ..... **Date** .....

Subscriber's Last Name: ___ ___ ___

Instruction Page

SUBSCRIBER INFORMATION *(Section 1)*

Employer Group Benefits Administrator: indicate Type of Transaction and applicable dates.

Subscriber: complete Reason for Transaction, Plan Selection, Type of Coverage and Subscriber's personal information.

Reason for Transaction: Check the appropriate action in the space provided. Your request **must** be received within 30 days of the event date. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Please see your Group Benefits Administrator/ Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Family Member or Loss of Coverage, you **must** also check coverage type and person(s) to be covered, and complete the Family Member Information section.

Plan Selection: Please note that all products may not be applicable to your employer group. Check with your Group Benefits Administrator/Representative.

FAMILY MEMBER INFORMATION *(Section 2)* If there are more than five family 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 eligible child age for your employer group: natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These family members have additional eligibility requirements. **Children pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled family member who is over the eligible child age for your employer group.**

MEDICARE INFORMATION *(Sections 1 and 2)*

If you or any of your family member(s) are Medicare eligible, complete the questions regarding Medicare Coverage.
Medicare Part B information is required if Medicare is/should be primary coverage.

PREVIOUS COVERAGE *(Section 3)*

The Subscriber is to provide the requested information regarding other insurance coverage (previous or current) for any and all active family members.

SUBSCRIBER RELEASE/SIGNATURE *(Section 4)* **The Subscriber must sign and date the Release Section of the form to be eligible for coverage.**

RELEASE

- I am applying to enroll myself and my eligible family members, if any, under the (Medical and/or Dental) certificate(s) or contract(s).
- 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 or certificate, 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 family members 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, Excellus BlueCross BlueShield may transmit personal information to third parties with which Excellus BlueCross BlueShield contracts, 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.
- **POINT OF SERVICE (POS)**
  I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.
- **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 that 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.

GROUP EMPLOYER INFORMATION *(Section 5)*

This section to be completed and signed by the Group Benefits 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