Excellus

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

SimplyBlue
GROUP ENROLLMENT FORM

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

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.

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

Dental Group # | Subgroup #

Subscriber Status:

☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

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 | COBRA Effective Date

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).

Copy Options
choose 1 Copy
$500 Single / $1,500 Family out of network deductible applies
☐ $10 PCP/$20 Specialist (LA)
☐ $15 PCP/$25 Specialist (LB)
☐ $25 PCP/$40 Specialist (LC)
☐ $30 PCP/$50 Specialist (L1)
☐ $40 PCP/$60 Specialist (L2)
☐ $40 PCP/$60 Specialist (LE)
$2,000 Single / $6,000 Family out of network deductible applies
☐ $30 PCP/$50 Specialist (LD)
$3,000 Single / $9,000 Family out of network deductible applies

HDHP Options
choose 1 Deductible
☐ $1,300 Single / $2,600 Family
☐ 20% Coinsurance (LH)
☐ 0% Coinsurance (LF)
☐ $1,800 Single / $3,600 Family (LI)
☐ $2,600 Single / $5,200 Family
☐ 20% Coinsurance (LJ)
☐ 0% Coinsurance (LG)
☐ $5,500 Single/ $11,000 Family (LK)

Copay & Deductible Option
choose 1 Deductible and 1 Copay
☐ $250 Single / $750 Family
☐ $10 PCP/$20 Specialist (LL)
☐ $15 PCP/$25 Specialist (LM)
☐ $25 PCP/$40 Specialist (LN)
☐ $30 PCP/$50 Specialist (LO)
☐ $40 PCP/$60 Specialist (LP)
☐ $500 Single / $1500 Family
☐ $10 PCP/$20 Specialist (LQ)
☐ $15 PCP/$25 Specialist (LR)
☐ $25 PCP/$40 Specialist (LS)
☐ $30 PCP/$50 Specialist (LT)
☐ $40 PCP/$60 Specialist (LU)
☐ $1,000 Single / $3,000 Family
☐ $10 PCP/$20 Specialist (LV)
☐ $15 PCP/$25 Specialist (LW)
☐ $25 PCP/$40 Specialist (LX)
☐ $30 PCP/$50 Specialist (LY)
☐ $40 PCP/$60 Specialist (LZ)

☐ $2,000 Single / $6,000 Family
☐ $10 PCP/$20 Specialist (M1)
☐ $15 PCP/$25 Specialist (M2)
☐ $25 PCP/$40 Specialist (M3)
☐ $30 PCP/$50 Specialist (L3)
☐ $40 PCP/$60 Specialist (L4)
☐ $2,000 Single / $6,000 Family with $500 per day inpatient copay
☐ $30 PCP/$50 Specialist (M4)
☐ $40 PCP/$60 Specialist (L9)
☐ $2,500 Single / $7,500 Family
☐ $30 PCP/$50 Specialist (L5)
☐ $40 PCP/$60 Specialist (L6)
☐ $3,000 Single / $9,000 Family
☐ $30 PCP/$50 Specialist (L7)
☐ $40 PCP/$60 Specialist (L8)

Please check coverage type and person(s) to be covered:

☐ Medical ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family
☐ Dental ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family

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 ☐ COBRA ☐ Retirement ☐ Loss of Coverage
☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Remove Dependent ☐ Change in Student Status
☐ 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

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

Middle Initial | Title | E-mail Address

Return Original to Excellus BlueCross BlueShield, at above address – Copy: Employer Group

Mailing Address

Apt or Suite

City

State Zip

Work Phone Number Home Phone Number Cell Phone Number

Date of Birth Gender M F Social Security Number

Marital Status: Single Married Legally Separated Divorced/ Marital Status Event Date

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

If Medicare eligible due to ESRD please check type of dialysis: Self administered Facilitated Date started

5 – Other Coverage Information

Have you ever been a member of Excellus BlueCross BlueShield? Yes No

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? No Yes / Dental? No Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? No Yes / Dental? No Yes

Who did the other plan cover? Self Spouse Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: Effective Date Termination Date

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber Medical Dental / Reason_____ Date

Dependent (list each dependent in section 7) Medical Dental / Reason _____ Date

7 – Dependent Information

Please provide all information for each person to be covered.

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

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

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

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

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

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

College/University Name Expected Graduation Date Credit hours

8 – Release/Signature

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 on the back.

Subscriber Signature_____ **Date**_____

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9 – Additional Dependents

Please provide all information for each person to be covered.

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

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

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

College/University Name | Expected Graduation Date | Credit hours

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

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

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

College/University Name | Expected Graduation Date | Credit hours

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

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

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

College/University Name | Expected Graduation Date | Credit hours

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

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

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

College/University Name | Expected Graduation Date | Credit hours

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

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

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

College/University Name | Expected Graduation Date | Credit hours