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HIOS ID#: 78124NY1000026-00

EC: SLI4

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply to you. Additional instructions are included.

- This application cannot be processed without this information and signatures

Section 1: Employer Group & Benefit Information - To be completed by the Group Administrator

Employer Name _____ Association/Chamber Name (if applicable) _____

Group Administrator's Signature (required) _____ Date _____ Employee Number _____ Department Number _____

Medical Information

Medical Group Number (8 digits) _____

Medical Subgroup Number (4 digits) _____

Medical Class Number (4 digits) _____

_____ /_____ /_____
Medical Effective Date

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

Dental Information

Dental Group Number _____

Dental Subgroup Number _____

Dental Class or Package Number _____

_____ /_____ /_____
Dental Effective Date

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

Subscriber Status: ☐New Hire ☐Rehire ☐Open Enrollment ☐Retired ☐COBRA

Medical Plan Selection

☐ SimplyBlue Plus Gold 6

Dental Plan Selection

☐Dental Blue Classic (DI) ☐Dental Blue Options (DJ)
☐Dental Other (DE)

Section 2: Subscriber's Information

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Last Name _____

First Name _____

Middle Initial _____ Title (e.g., Jr, Sr, III, etc.) _____

Street Address _____

City _____ State _____

Zip Code _____ Phone _____

Birthdate ____ /____ /_____

Gender: ☐Male ☐Female

Social Security # ** _____

Date of Hire/Rehire: ____ /____ /_____

Retire Date: ____ /____ /_____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced Marital Status Event Date: ___ /___ /_____

Subscriber's Medicare Number (if applicable) _____

_____ /_____ /_____ **Part A** Effective Date

_____ /_____ /_____ **Part B** Effective Date

☐Age 65+ ☐Disability
☐End Stage Renal *

Section 3: Please indicate the reason for this enrollment or change - To be completed by the Group Administrator

Special Enrollment Opportunity:

☐Change in employment status ☐A move in or out of the service area **Date of Event ___ /___ /_____**
☐Involuntary loss of coverage ☐Former dependent regains eligibility
☐Medicare Eligible ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other _____

Termination of Coverage: See Section 4

☐Canceled - Effective Date: ____ /____ /_____
☐Change to new employer that does not offer insurance ☐Remove Dependent
☐Loss of eligibility through employer ☐Discontinuation of employer coverage
☐Dependent reaches maximum age of coverage ☐Death

☐**COBRA Election**- Effective Date: ____ /____ /_____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: _____

Demographic Change:

☐Address Change ☐Subscriber Name Change ☐Marital Status Change: ☐Married ☐Divorced
☐Birthdate Change ☐Dependent Name Change ☐Phone Number Change

Section 4: If canceling coverage, who are you canceling coverage for?

☐Subscriber - ☐Medical Cancellation Date ____ /____ /_____ ☐Dental Cancellation Date ____ /____ /_____

☐Dependent(s) - ☐Medical Cancellation Date ____ /____ /_____ ☐Dental Cancellation Date ____ /____ /_____
(List each dependent)

Spouse/DP_____ **Dependent 2**_____ **Dependent 3** _____ **Dependent 4** _____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Coverage through spouse/domestic partner
☐Left Employment ☐Loss of eligibility through employer ☐Other _____
☐Medicare/Medicaid or other coverage ☐Discontinuation of employer coverage

Section 5: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)
☐Other_____

_____ _____ _____ _____
Last Name (if different) First Name MI Social Security # **

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No Expected
If yes, please provide name of college/university _____ Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
Last Name (if different) First Name MI Social Security # **

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No Expected
If yes, please provide name of college/university _____ Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_____

_____ _____ _____ _____
Last Name (if different) First Name MI Social Security # **

Gender: ☐Male ☐Female Birthdate ___ /___ /_____

Is dependent a full time student over age 19? ☐Yes ☐No Expected
If yes, please provide name of college/university _____ Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

_____ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 6: Other coverage information (Required) **You may be contacted for additional information**

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No
If yes, what type of coverage? ☐Medical ☐Dental
What is the effective date of the other coverage? ☐Medical: ____ /____ /_____ ☐Dental: ____ /____ /_____
What is the name of the other carrier? _____
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? ____ /____ /_____
Policyholder's name _____ ID# _____
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract 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 accepts 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 hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

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.

Subscriber Signature _____ **Date** _____

Please return to P.O. Box 21146 Eagan, MN 55121
If you have questions, please contact your Group Administrator.
Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1: Employer Group & Benefit Information
This section should be completed by a Group Administrator. Medical and/or dental group information must be populated. Select who you want to cover on your medical and/or dental plan(s) and indicate the subscriber's status. Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information
This section should be completed by the Subscriber.
**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 3: Please indicate the reason for this enrollment or change
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. 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 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 complete the Dependent Information section.

You may be required to provide documentation of certain events.

Section 4: If canceling coverage, who are you canceling coverage for?
If you are canceling coverage, select who you are canceling coverage for and enter the date the coverage is to be canceled. List each applicable dependent to be canceled. Then select your reason for canceling.

Section 5: Information about who you would like coverage for
Please include information about all the people who you would like coverage for.
Use an additional application if more than four people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.