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HIOS ID#: **78124NY1000058-00**

EC: **SJLO**

## 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 Silver 2**

#### Dental Plan Selection

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

### Section 2: Subscriber's Information

\_\_\_\_\_  
 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 \*

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

**Enrollment Opportunity:**

- Open Enrollment/New Hire/Rehire       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 \_\_\_\_\_
- Change in employment status

**Termination of Coverage:** Also, see Section 4

- Canceled - Effective Date: \_\_\_ / \_\_\_ / \_\_\_       Remove Dependent
- Change to new employer that does not offer insurance       Discontinuation of employer coverage
- Loss of eligibility through employer       Death
- Dependent reaches maximum age of coverage
- 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 Graduation Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
If yes, please provide name of college/university \_\_\_\_\_

Medicare Eligible  Yes    No                      If yes, indicate reason    Age 65+                       Disability                       End Stage Renal \*  
\_\_\_\_\_  
Medicare Number (if applicable)                      Part A Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_                      Part B Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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](http://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.