Excellus
A nonprofit independent licensee of the Blue Cross Blue Shield Association

Individual & Family Health Insurance Application/Change Form

For Internal Use

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

FOR INTERNAL USE ONLY

HIOS ID# 78124NY0900014-00
EC IAN6

Section 1: Your Information (REQUIRED)

Subscriber ID# _____

Last Name | First Name | MI (For changes and cancellations)

Social Security # **_____ Birthdate _____

Gender:
☐Male ☐Female
☐Gender X

Gender identity **(optional)**:
☐Transgender Male ☐Prefer not to say
☐Transgender Female ☐Non-binary
☐Prefer to self-describe:

Street Address | City | State | Zip | County

Mailing Address (if different) | City | State | Zip | County

Billing Address (if different) | City | State | Zip | County

Phone 1 (primary) | Phone 2 (secondary) | Email

Would you like to receive emails about health & wellness? ○YES ○NO

Section 2: What do you need to do?

☐ Enroll in a new plan ☐ Add dependent(s) to current coverage ☐ Cancel coverage
☐ Change current coverage ☐ Remove a dependent ☐ Name or address change

Section 3: If enrolling in a new plan, who do you need coverage for?

☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family ☐Child Only
Effective Date

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

☐Self Only ☐Self & Child(ren) ☐Self & Spouse/Domestic Partner ☐Family ☐Child Only
Cancelation Date_____

Why are you canceling coverage?

☐Subscriber's request ☐Coverage through spouse ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage

Section 5: Special Enrollment Period

If you are applying outside of the annual Open Enrollment Period, please check one of the events below that applies to you. The Special Enrollment Period begins on the date of the event checked and continues for 60 days.

☐ Loss of coverage ☐Marriage ☐Birth ☐Adoption ☐Domestic Partnership ☐Death ☐Pregnancy ☐Domestic Violence

Section 6: Plan options

(A) Plan Options (You may only select one)	(B) Dependent Coverage to Age 29	(C) Child Only (Only available if you select a Standard plan option in Column A. If selected your child will be covered until age 21.)
Bronze Select	**NO**	**NO**

Section 7: Pediatric dental coverage

Please answer the following questions:

Have you obtained stand-alone dental coverage that provides apediatric dental essential healthbenefit through a NY State of Health-certified stand-alone dental plan offered outside of the NY State of Health?

NO

IF YES

Please provide the nameof the company issuing the stand-alone dental coverage.

_____

IF NO

We will provide you with coverage of the pediatric dental essential health benefit.

- At an additional charge

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

What other coverage do you or your family have? ☐Medicare ☐Medicaid ☐Medical ☐Dental ☐None (move to Section 9)

What is the effective date of the other coverage? ☐ Medical: _____ /_____ /_____ ☐ Dental: ____ /____ /_____

What is the name of the other carrier(s)? _____ _____

Are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage end? ☐ Medical: _____ /_____ /_____ ☐ Dental: _____ /____ /_____

Policyholder's name_____ID#(s) _____

Did the insurance cover ☐Insured ☐Insured and family

Section 9: Information about who you would like coverage for

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____

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

Gender identity **(optional)**: ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe:_____

_____ _____

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

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____

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

Gender identity **(optional)**: ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe:_____

_____ _____

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

☐ Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other____________________

Birthdate ______/______/___________ Gender: ☐Male ☐Female ☐Gender X

Gender identity **(optional)**: ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe:___________

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

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Birthdate ______/______/___________ Gender: ☐Male ☐Female ☐Gender X

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

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Birthdate ______/______/___________ Gender: ☐Male ☐Female ☐Gender X

Gender identity **(optional)**: ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Prefer not to say ☐Prefer to self-describe:___________

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

Section 10: Third party administrator must complete this section (Broker, Agent, Internal Sales, and Certified Application Counselor (CAC)/ Marketplace Facilitated Enroller (MFE) – If a broker, license # for the agency must be completed to be eligible for commission)

Name of Broker/Agent/CAC/MFE/Person assisting ____

Agency Name (if applicable____

Agency License # (if applicable) ______________________ Agency Tax ID (if applicable) ______________________

Section 11: Release – You must sign and date this form to be eligible for health insurance.

Pursuant to federal rules that implement the Affordable Care Act, individual health insurance policies must be written on a calendar year basis. This means that if your effective date of coverage is a date later than January 1st of a year, the initial term of coverage for your policy will be for less than a full year and will end on December 31st of the same year. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage.
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 acknowledgment 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.
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.
I have thoroughly read, understand, and agree to comply with the terms of this Release section.

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**________________

Instructions for completing Individual & Family Health Insurance Application

Section 1: The entire section is REQUIRED to be completed by the subscriber. For child only plans, the parent or guardian's information is REQUIRED in this section. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 2: Select the box that describes what you need to do regarding health insurance coverage.

Section 3: Select the box that describes who you need coverage for. Please complete section 7 if you select any box other than self only. Effective dates are determined based upon the date you request provided you are enrolling by the 25th of the month to be effective the first of the following month. Retroactive requests for coverage and other effective dates may be allowed forcertain qualifying events.

Section 4: If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 5: There are certain life changes that make you eligible for a Special Enrollment Period (SEP) such as having a baby, getting married or your coverage under another plan is ending. Select the event that applies to you and include the date of the event. You may be required to provide documentation of certain events. *Please contact our dedicated Insurance Advisors at 1-888-579-0327 for a list of documentation required.

Section 6: Column A – Select one plan option only. Column B – Select this option if you would like to purchase additional coverage for dependents age 26 – 29. Dependents will be covered until end of the month the Dependent turns 30 years of age (cannot be selected in conjunction with a Child-Only plan). Column C – Select a child only plan if you need coverage for a child or children up to age 21.

Section 7: Indicate whether you have stand-alone pediatric dental coverage through a NY State of Health plan or through a different insurance company. If your coverage is through another company, please include the name of the company. If you indicate that you do not have a stand-alone pediatric dental plan through a different insurance company; understand that we will automatically enroll you in the medical plan you selected that includes pediatric dental care for an additional cost.

Section 8: Please include accurate information in this section. This could affect the processing of your application and/or claims. Medicaid is a public aid program for those with a limited income. This is not the same as Medicare.

If you are Medicare eligible and enrolled in Medicare Part A and/or Medicare Part B, do not complete this application. Please contact one of our dedicated Insurance Advisors at 1-888-579-0327 for the Supplemental Medicare Eligible Enrollment Form or a Medicare Advantage plan enrollment application

Section 9: Please include information about all the people for whom you would like coverage. Use an additional application if more than five people need coverage. There are additional eligibility and documentation requirements for coverage of dependents noted with an asterisk (*) below. 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)
- Dependent under the age of 26 – Natural, adopted* or stepchild
- Child (ren) Only coverage is available for children up to age 21
- Disabled Dependents* over the dependent age
- Dependents by legal guardianship*
- *Please contact our dedicated Insurance Advisors at 1-888-579-0327 or visit our website ExcellusBCBS.com for information and any required form(s). Eligibility Requirements are outlined in the Member Contract.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable CareAct.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Section 10: This section is to be completed by the Third-Party Administrator who may be assisting you with your enrollment process. A third-party administrator can be an authorized agent or broker and to the extent permitted by the Federal and State law and regulation, any other third-party assistors. If you are not working with a Third-Party Administrator, you can disregard this section.

Section 11: Subscriber signature and date are required in this section.

YOUR PREMIUM PAYMENT MUST BE INCLUDED WITH THE APPLICATION

Please mail application and payment to:

Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

If you have questions, please contact our dedicated Insurance Advisors at 1-888-579-0327
Learn about exclusive member benefits at ExcellusBCBS.com/FindAPlan