BlueCross BlueShield of Western New York

Employer Group Enrollment Form for Societies

Group Administrator Name _____

Member Group Name _____

Member Physical Address _____

Member Mailing Address _____

Member Telephone _____ **Contact Person** _____

Employer Federal ID No. if applicable _____**Member of Group since** ___/___/___

The following requirements apply: The purpose of this documentation is to assure the group has a legitimate existence, and was not formed solely for the purpose of seeking insurance.

To be eligible for enrollment, the following requirements must be met. The applicant must:

1. Submit their **membership information above to attest to active membership within the Group**.
2. If a member has an employee requesting insurance, **a NYS-45 ATT** must be submitted to substantiate their active employment.
3. **The group administrator must attest that members are current and up to date on their dues.** The appropriate documentation must be attached to this submission. All paperwork, including applications, must be received by the **15th of the month** prior to the effective date.

Groups with NYS-45 ATT - please check all appropriate boxes

☐ I am enclosing the most recent Schedule C and/or NYS-45 ATT for my business.

☐ All of my covered employees are listed on the NYS-45 ATT.

☐ These newly hired employees will be listed on my next NYS-45 ATT. I am enclosing copies of these employees' 2 most recent paystubs.

Name _____ Name _____

☐ One or more of my covered employees are not listed on the NYS-45 ATT. If retired or on COBRA enter the month and year of retirement or COBRA. Enclosed is a copy of the last NYS-45 ATT on which the retiree or employee on COBRA appeared. Please list owners name(s) not appearing on the NYS-45 ATT and submit the appropriate IRS schedule listed below.

Name _____ **Reason** _____

Name _____ **Reason** _____

Group Administrator Attestation

☐ As the group administrator, I attest that that the member listed above maintains active and up to date Membership with our group, meeting all of our requirements, and is current with membership dues.

Name _____ Date_____

By signing below the group certifies that they meet the eligibility requirements to be enrolled. I certify that the above information is true and accurate to the best of my knowledge. I understand that enrollment is subject to **BlueCross BlueShield of Western New York** underwriting guidelines and the Group Health Care contract between the Society and **BlueCross BlueShield**. I understand that **BlueCross BlueShield** will conduct annual audits to ensure compliance with these guidelines, which may require us to provide verification of our being a legitimate member of the Group.

_____ _____

Member's Signature Date