BlueShield
of Northeastern New York
A Division of HealthNow New York Inc. An Independent Licensee of the BlueCross BlueShield Association
PO Box 80, Buffalo, NY 14240-0080

Enrollment Application/Change Form

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

Subscriber Status:
○ Active ○ Retired ○ COBRA

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: M M D D Y Y
COBRA Effective Date: M M D D Y Y
Hire/Rehire Date: M M D D Y Y
Retired Effective Date: M M D D Y Y

2 – Subscriber Plan Selection

Please use blue or black ink, print one character per box. Check applicable plan(s).

Traditional Blue Plan Number:
○ POS ○ EPO ○ Dental
○ PPO ○ Traditional ○ Vision

Community Blue Plan Number:
○ HMO ○ HMO Plus
○ Other

Please indicate HMO or HMO Plus copay:
PCP $ Specialist $

Please choose coverage type Single or Family:
○ Medical ○ S ○ F
○ Dental ○ S ○ F
○ Vision ○ S ○ F

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

○ New Hire ○ COBRA ○ Primary Care Physician ○ Remove Dependent ○ Loss of Coverage
○ Open Enrollment ○ Address/Phone Number ○ Last Name ○ Retirement

○ 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 ○ Change in Student Status

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 | M.I. ○ Male ○ Female

Social Security Number | Date of Birth M M D D Y Y | Telephone Number (include area code)

Marital Status:
○ Single
○ Married
○ Legally Separated
○ Divorced
○ Widowed

Mailing Address ○ Apt ○ Suite

City | State | Zip Code

E-mail Address

Marital Status Event Date M M D D Y Y

Medicare Number (if applicable)
Part A Effective Date M M D D Y Y
Part B Effective Date M M D D Y Y
Part D Effective Date M M D D Y Y

Form # CN9XAN0002

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4 – Subscriber Information continued

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number (see directory)

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient? ◯ Yes ◯ No

Do you have additional group health insurance? ◯ Yes ◯ No

Name of Prior Health Care Insurer

Policy Identification Number

Policy Effective Date M M D D Y Y

Policy Cancellation Date M M D D Y Y

5 – Dependent Information

Please provide all information for each person to be covered.

Spouse/Domestic Partner Last Name

Spouse/Domestic Partner First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

◯ Male

◯ Female

Are you enrolling as a Domestic Partner? ◯ Yes ◯ No

Medicare Number (if applicable)

Part A Effective Date M M D D Y Y

Part B Effective Date M M D D Y Y

Part D Effective Date M M D D Y Y

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient? ◯ Yes ◯ No

Do you have additional group health insurance? ◯ Yes ◯ No

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

◯ Male

◯ Female

Is your over-age dependent handicapped? (See instructions for additional information) ◯ Yes ◯ No

Medicare Number (if applicable)

Part A Effective Date M M D D Y Y

Part B Effective Date M M D D Y Y

Part D Effective Date M M D D Y Y

Is dependent a full-time student? ◯ Yes ◯ No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date M M D D Y Y

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient? ◯ Yes ◯ No

Do you have additional group health insurance? ◯ Yes ◯ No

5 – Dependent Information continued
Please provide all information for each person to be covered.

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

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth M M D D Y Y

○ Male ○ Female

Is your over-age dependent handicapped? ○ Yes ○ No
(See instructions for additional information)

Medicare Number (if applicable)

Part A Effective Date M M D D Y Y | Part B Effective Date M M D D Y Y | Part D Effective Date M M D D Y Y

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

College/University Name | Expected Graduation Date M M D D Y Y

Primary Care Physician's Last Name | Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Do you have additional group health insurance? ○ Yes ○ No

HMO/POS Coverage

If you chose HMO or POS coverage, you are entitled to direct access to care from any participating provider without obtaining a referral for the following:

- Ob/Gyn
- Hospital stay for members who have undergone a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer.
- Following a mastectomy, coverage for breast reconstruction on the affected breast and the other breast necessary to produce a "symmetrical" appearance.
- Second medical opinion following any positive or negative treatment of cancer.

Other medical care should be coordinated by your participating Primary Care Provider (PCP) whom you have chosen and listed on this application.

Traditional Indemnity Coverage

- If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective date of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
- We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.

6 – Disclosure / Signature
Subscriber signature *required.*

Important: Please read and sign below:

*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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

X **Subscriber Signature:** ____________________ **Date:** __________