BlueCross BlueShield
of Western New York

[redacted]

PO Box 80, Buffalo, NY 14240-0080

Enrollment Application/Change Form — SMALL

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.

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

Group # | Subgroup # | Class #

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

Effective Date (MMDDYY)

COBRA Effective Date (MMDDYY)

Hire/Rehire Date (MMDDYY)

Retired Effective Date (MMDDYY)

2—Subscriber Plan Section Please use blue or black ink, print one character per box. Check applicable plan(s).

Plan Number:

Please indicate copay: PCP $ Specialist $

◯ POS ◯ POS Plus ◯ Dental ◯ HMO ◯ HMO Plus
◯ PPO ◯ Traditional ◯ Vision ◯ EPO ◯ Aqua ◯ Other

Please choose coverage type

Single or Family:

◯ Medical ◯ S ◯ F
◯ Dental ◯ S ◯ F
◯ Vision ◯ S ◯ F

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ◯ Yes ◯ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

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

◯ 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.

Social Security Number | Date of Birth (MMDDYY) | Telephone Number (include area code) | Gender: ◯ Female ◯ Male

Mailing Address ◯ Apt ◯ Suite

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Legally Separated ◯ Widowed

City | State | Zip Code

E-mail Address

Marital Status Event Date (MMDDYY)

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable) | Part A Effective Date (MMDDYY) | Part B Effective Date (MMDDYY) | Part D Effective Date (MMDDYY)

-over-

4 Subscriber Information continued

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

Name of Prior Health Care Insurer

Policy Identification Number

Policy Effective Date (MMDDYY)

Policy Cancellation Date (MMDDYY)

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

Spouse/Domestic Partner's Last Name

Spouse/Domestic Partner's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: ◯ Female ◯ Male

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

E-mail Address

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable)

Part A Effective Date (MMDDYY)

Part B Effective Date (MMDDYY)

Part D Effective Date (MMDDYY)

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

Name of Prior Health Care Insurer

Policy Identification Number

Policy Effective Date (MMDDYY)

Policy Cancellation Date (MMDDYY)

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

E-mail Address

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable)

Part A Effective Date (MMDDYY)

Part B Effective Date (MMDDYY)

Part D Effective Date (MMDDYY)

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

College/University Name

Expected Graduation Date (MMDDYY)

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

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

5—Dependent Information continued

Please provide all information for each person to be covered.

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

Social Security Number | Date of Birth (MMDDYY)

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

Social Security Number | Date of Birth (MMDDYY) | Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

E-mail Address

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable) | Part A Effective Date (MMDDYY) | Part B Effective Date (MMDDYY) | Part D Effective Date (MMDDYY)

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

College/University Name | Expected Graduation Date (MMDDYY)

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

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

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

Social Security Number | Date of Birth (MMDDYY) | Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

E-mail Address

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable) | Part A Effective Date (MMDDYY) | Part B Effective Date (MMDDYY) | Part D Effective Date (MMDDYY)

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

College/University Name | Expected Graduation Date (MMDDYY)

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

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

-over-

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 (MMDDYY) | Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

E-mail Address

◯ Medicare Eligible Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

Medicare Number (if applicable) | Part A Effective Date (MMDDYY) | Part B Effective Date (MMDDYY) | Part D Effective Date (MMDDYY)

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

College/University Name | Expected Graduation Date (MMDDYY)

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

If you answered "yes" to the question about stand-alone dental coverage in section 2, please provide the name of the company issuing the coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit.

HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and;
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

6—Disclosure / Signature

Subscriber signature required.

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 AND IS VALID FOR UP TO 24 MONTHS.

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.**

Subscriber Signature _____ **Date** _____