



A nonprofit independent licensee of the Blue Cross Blue Shield Association

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HIOS ID# _____
EC _____

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Employer Name		Association/Chamber Name (if applicable)		Check Desired Action <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
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 (e.g. A001)		If enrolling in a Medical plan, who do you need coverage for? <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren) <input type="checkbox"/> Self & Spouse, or Self & Domestic Partner <input type="checkbox"/> Family _____ / _____ / _____ Medical Effective Date	Subscriber Status: <input type="checkbox"/> Actively Working <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Canceled <input type="checkbox"/> COBRA	Dental Information Dental Group Number Dental Subgroup Number Dental Class _____ / _____ / _____ Dental Effective Date	
Medical Plan Selection		Dental Plan Selection			

Section 2: Subscriber's Information

Last Name		Birthdate: _____ / _____ / _____	
First Name		Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Middle Initial Title (e.g., Jr, Sr, III, etc.)		Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____	
Street Address		Social Security Number** _____	
City		State _____	
Zip Code		Phone _____	
Date of Hire/Rehire: _____ / _____ / _____ Retirement Date: _____ / _____ / _____ <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *			
Subscriber's Medicare Number (if applicable) _____ / _____ / _____ _____ / _____ / _____ Medicare Part A Effective Date Medicare Part B Effective Date			

Section 3: Reason for enrollment or change To be completed by the Group Administrator Not required for cancellations

Enrollment Opportunity:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Rehire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Medicare eligible
Special Enrollment Opportunity:	<input type="checkbox"/> Newly Eligible Dependent: <input type="checkbox"/> Newborn <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____			
<input type="checkbox"/> Change in employment status	<input type="checkbox"/> A move in or out of the service area			
<input type="checkbox"/> Involuntary loss of coverage	<input type="checkbox"/> Former dependent regains eligibility			

Date of Event ____ / ____ / ____

COBRA Election - Please indicate the reason for COBRA if applicable:

<input type="checkbox"/> Left Employment/Retired	<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Loss of Student Status	<input type="checkbox"/> Death of Spouse
<input type="checkbox"/> Disability	<input type="checkbox"/> Dependent Reached Max Age <input type="checkbox"/> Other: _____		

Demographic Change: Address Birthdate Subscriber Name Dependent Name Phone Number**Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?**

Subscriber	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:	
		/ /	/ /	
Cancel Codes: SB02-Left Employment	SB05-Per Group Request	SB06-Subscriber Request (voluntary)	SB07-Deceased	
			SB09-Enrolled in Error	
Dependent(s)	Dependent Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:
			/ /	/ /
			/ /	/ /
			/ /	/ /
Cancel Codes: M001-Per Group Request M002-Deceased M003-Per Subscriber Request	M004-Enrolled in Error M005-Divorced M007-Per Member Request (voluntary)	M008-Moved Out of Area M010-Overage Dependent M011-No Longer a Student	M013-Ineligible M014-YAO Ineligible M040-Mx Same Group	

Section 5: Information about who you would like coverage for (dependent information)

<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> Disabled Dependent Child (Separate application form required)
<input type="checkbox"/> Other _____			

Last Name (if different)	Title	First Name	MI	Social Security Number **
Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate ____ / ____ / ____				
Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Graduation Date: ____ / ____ / ____	
If yes, please provide name of college/university _____				
Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *		
		Part A Effective Date: ____ / ____ / ____	Part B Effective Date: ____ / ____ / ____	
Medicare Number (if applicable)				

↓ Additional Dependent(s) ↓

<input type="checkbox"/> Dependent Child	<input type="checkbox"/> Disabled Dependent Child (Separate application form required)	<input type="checkbox"/> Other _____		
Last Name (if different)	Title	First Name	MI	Social Security Number **
Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate ____ / ____ / ____				
Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Graduation Date: ____ / ____ / ____	
If yes, please provide name of college/university _____				
Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> 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)	Title	First Name	MI	Social Security Number **
Gender assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate: _____ / _____ / _____ Gender identity (optional): <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Prefer to self-describe: _____				
Is dependent a full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No Married? <input type="checkbox"/> Yes <input type="checkbox"/> No Expected Graduation Date: _____ / _____ / _____ If yes, please provide name of college/university _____ Will dependent further education after graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medicare Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate reason <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal *		
		Part A Effective Date: _____ / _____ / _____ Part B Effective Date: _____ / _____ / _____		
Medicare Number (if applicable)				

Note: Use an additional application [or addendum] if more than three dependents 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? Medical: _____ / _____ / _____ Dental: _____ / _____ / _____

Policyholder's name _____ ID#(s) _____

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 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.

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.

PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this 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** _____

Please return to P.O. Box 21146 Eagan, MN 55121-0146

If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application/Change Form

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. 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.

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 3: Reason for 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. You may be required to provide documentation of certain events.

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

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application or addendum if more than three dependents 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 county clerk)
- 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 disabled dependent who is over the maximum 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.

A separate Adult Disabled Dependent application form is required for applicable dependents. Please contact your Group Administrator for the appropriate forms.

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.