**YOU MUST PROVIDE THIS INFORMATION
IF SIGNING UP FOR FAMILY COVERAGE

**Joseph J. Bufano**
HR Director / School Attorney
315-433-2631 phone; 315-433-2650 fax
jbufano@ocmboces.org

Employee Name ____________________________________

Date of Notification _________________

Our health plan is part of the Cooperative Health Insurance Fund of CNY ("Cooperative"). The Cooperative has determined that we must participate in an ongoing Dependent Eligibility Audit in order to make sure we are only covering the costs of eligible dependents. As a member of the plan, you are required to participate in the audit by providing documentation regarding your dependents covered under the health care plan.

**Who Is Considered a Dependent?**

The following family members are considered eligible dependents: legal spouse, child (biological, adopted, step-child, or legal ward) up to age 26, and disabled child (biological, adopted, step-child, or legal ward) age 26 and older.

**What Do You Need to Do?**

We ask that you provide documentation to prove the eligibility of all dependents listed on your health insurance plan. Please review the eligibility rules and documentation required for each dependent on the back of this letter. Submit required documentation to Tammy Jones immediately (interoffice mail: Administration Bldg., Personnel Office, Henry Education Campus or US Mail: PO Box 4754, Syracuse NY 13221). **Failure to provide documents in a timely manner will result in cancellation of coverage for any dependent(s) not verified.**

**Your Support Is Appreciated!**

We understand that gathering dependent information requires an effort from you and your family. The cost of health coverage is shared by all of us. By taking steps to use the benefits efficiently, we all help to keep costs low and quality of care high. We want to thank you in advance for your cooperation. ALL dependents covered by the health plan must be documented. Contact Tammy Jones in the Personnel Office at 315-433-2632 with any questions.

## ELIGIBILITY RULES AND DOCUMENTATION REQUIRED

Below is a list of eligibility rules and documents required to verify your dependent(s). In many cases, at least **TWO** documents are required per dependent. Please read carefully. **DO NOT SEND ORIGINALS!** Send copies only or hand deliver originals for verification – **no documents will be returned.** All copies provided to us will be destroyed upon review and verification of eligibility.

| Dependent Type | Age | Eligibility Requirements |
|---|---|---|
| **Legal Spouse** | N/A | ▸ The covered employee's husband or wife under Federal Law |

**Document Options for Verifying Eligibility** (any one of the following document sets):

- Government Issued Marriage Certificate **AND** Federal Tax Return within last 2 years listing spouse*****
  ***Only send 1st page of tax return that shows your dependents. Black out monetary amounts**
- Government Issued Marriage Certificate **AND** Proof of Joint Ownership issued within last 6 months
- Government Issued Marriage Certificate Only (if married in the last 12 months)

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**Biological Child** Up to Age 26 ▸ Must be the employee's biological child

**Document Options for Verifying Eligibility** (any one of the following documents)**:**

- Government Issued Birth Certificate (including Parents' Names).
- If a newborn child (Birth to 3 months of age), you may submit the Hospital Birth Certificate (including Parents' Names)

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**Adopted Child** Up to Age 26 ▸ Must be the employee or spouse's adopted child

**Document Options for Verifying Eligibility** (any one of the following document sets)**:**

- Adoption Placement Agreement including Child's Birthdate or Petition for Adoption including Child's Birthdate
- Adoption Certificate including Child's Birthdate

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**Step-Child** Up to Age 26 ▸ Must be the biological child of the employee's spouse

**Document Options for Verifying Eligibility** (any one of the following document sets)**:**

- Government Issued Birth Certificate (including Parents' Names), **AND** Government Issued Marriage Certificate **AND** Federal Tax Return within last 2 years listing spouse
- Government Issued Birth Certificate (including Parents' Names) **AND** Government Issued Marriage Certificate (if married within last 12 months)
- Government Issued Birth Certificate (including Parents' Names) **AND** Government Issued Marriage Certificate **AND** Proof of Joint Ownership issued within last 6 months

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**Legal Ward** Up to Age 26 ▸ Must be the employee or spouse's legal ward

**Document Options for Verifying Eligibility:**

- Government Issued Birth Certificate **AND** Court Ordered Document of Legal Guardianship of the child to the subscriber or spouse. (Custody agreements or orders do not convey Legal Guardianship.)
- Proof of Financial Dependency

# OCM BOCES Group Health Insurance Enrollment/Change Form

Coverage: **Classic Blue Regionwide**
Excellus BC/BS, PO Box 22999, Rochester NY 14692

Date of Hire or Event __01_/_01__/_21__ Effective Date: _01__/_01__/_21__ *OPEN ENROLLMENT

✓ **CHECK DESIRED ACTION:**
☑ Enrollment ☐ Add Dependent ☐ Transfer to COBRA ☐ Name Change ☐ Cancel: (✓ ☐Subscriber ☐Dependent Reason Code: ___)

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**SUBSCRIBER INFORMATION: MUST BE COMPLETED** ✓ Persons Covered: ☐Employee Only ☐Employee with Dependents
Social Security Number: _________-________-__________ Sex: ☐M ☐F Birthdate: _____/_____/_____
Last Name:_______________________________________ First Name: ___________________________
Street Address: ___________________________________________________________________________
City: _______________________________ State: _______ Zip: __________ Phone: ( ) _____ ____________
Do you have Medicare? ☐Yes ☐No If yes, indicate reason: ☐Age ☐Disabled ☐ESRD
Medicare Claim #: ____________________
Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/___

**OTHER COVERAGE INFORMATION: MUST BE COMPLETED** *You may be contacted for additional information.*
Have you or any member of your family been enrolled in any **other** insurance policy in the last 63 days (including Medicare or Medicaid)?
☐Yes ☐No If yes, are you keeping this coverage? ☐Yes ☐No (If No, indicate cancel date: ____/____/____)
Policy Holder Name: ___________________________ Effective Date: ___/___/___ ID# ______________________
✓ Persons Covered: ☐Single ☐Family Name of other insurance company: ______________________________

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**FAMILY MEMBER INFORMATION:** *(Complete this section if applicable)* ✓ One: ☐Add ☐Remove
✓ Relationship: ☐Spouse (Date of Marriage: ___/___/___) ☐Dependent Child/Stepchild
Last Name: _______________________________________ First Name: ___________________________
Social Security #:_________________________ Sex: ☐Male ☐Female Birthdate: _____/_____/_____
Enrolled with Medicare? ☐Yes ☐No If yes, indicate reason: ☐Age ☐Disabled ☐ESRD
Medicare Claim #: _________________________ Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/___

✓ Relationship: ☐Dependent Child/Stepchild
Last Name: _______________________________________ First Name: ___________________________
Social Security #:_________________________ Sex: ☐Male ☐Female Birthdate: _____/_____/_____
Enrolled with Medicare? ☐Yes ☐No If yes, indicate reason: ☐Age ☐Disabled ☐ESRD
Medicare Claim #: _________________________ Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/___

✓ Relationship: ☐Dependent Child/Stepchild
Last Name: _______________________________________ First Name: ___________________________
Social Security #:_________________________ Sex: ☐Male ☐Female Birthdate: _____/_____/_____
Enrolled with Medicare? ☐Yes ☐No If yes, indicate reason: ☐Age ☐Disabled ☐ESRD
Medicare Claim #: _________________________ Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/___

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**RELEASE – You must sign and date this form to be eligible for insurance.**
I have thoroughly read, understand and agree to comply with the terms of the Release on the back of this form. I certify that all statements made by me on this application are true and complete. I understand that any false or misleading statements made by me will be considered justification for disqualification of my enrollment and possible termination of employment.

**Subscriber Signature:** _____________________________________________ **Date:** ____________________

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Employer Information (Must be completed by Group Representative)
Employee Status: ☐Active ☐Cobra ☐Termination ☐Retired
Was employee subject to a waiting period? ☐Yes ☐No If yes, (start date: ___/___/___ and end date: ___/___/___)
Group Rep Signature: ______________________________ Date: ___________ Group Number____00063240-0003________

**Instructions for completing the Enrollment/Change Form**

**DESIRED ACTION** – Check the appropriate action and indicate the Effective Date. 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 Representative for events that fall outside the 30-day period. If enrolling, you must complete the Subscriber Information, Other Coverage Information, Family Member Information (if enrolling family members) and sign the Release section.

**Cancel Reasons:**

| **Subscriber:** | **Dependent:** |
|---|---|
| LE - Left Employer/No Longer Eligible | OA – Dependent Over Age |
| SD – Subscriber Deceased | DM – Dependent Deceased |
| SR – Subscriber Request | MS – Ineligible Student |
| CB – Cobra Begin Date | SR – Subscriber Request |
| | DV - Divorce |

**FAMILY MEMBER QUALIFIED GUIDELINES:**

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group (natural, adopted or stepchild)
- Other: Please contact your Group Administrator/Representative for the appropriate form.
  These dependents have additional eligibility requirements.
  **Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.**

**RELEASE**

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- 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.
- I hereby represent that all information furnished by me heron is true and complete to the best of my knowledge.

**If you have questions, please contact your Group Administrator/Representative**
**Or, visit:**
**www.excellusbcbs.com/cnycoop**