# FLASHP
# GROUP ENROLLMENT FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#________________________________

EC_____________________________________

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

**Instructions on last page. All Dates = mm/dd/yy**

**PLEASE PRINT CLEARLY**

## 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 # 00044316    Subgroup # ________    Class# ________

Employer Name: Romulus CSD

Association/Chamber Name (if applicable): N/A

Group Administrator Signature/Date: X

Dental Group # ____________________ Subgroup # ____________

Subscriber Status:

____ Active ____ Retired _____ COBRA _____ Cancelled

Please indicate reason for COBRA:

___ Left Employ/Retirement ___ Death of Spouse

___ Divorce/Legal Separation ___ Dependent Reached Max Age

___ Other ________________

Effective Date ________________ COBRA Effective Date ________________

Hire/Rehire Date ________________ Retired Effective Date ________________

Subscriber Name:______________________________________________

Was the employee subject to a waiting period before enrolling in your employer health plan? ____ No ____ Yes

If yes, what was the start date: ______________ and end date _________________

## 2 – Subscriber Plan Selection

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

| Medical | Dental | Coverage |
|---|---|---|
| **Blue Point 2 $15/$15**<br>☐ $5/$15/$30 RX (EF) | **Dental** (DE)<br>☐ Dental Blue Option 3 | Please check coverage type and person(s) to be covered:<br>Medical: ☐ single ☐ 2 person ☐ family no spouse ☐ family<br>Dental: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family |
| **Healthy Blue Copay**<br>☐ $15 PCP/$25 Specialist (A1)<br>☐ $30 PCP/$50 Specialist (A3) | **Dental** (DE)<br>☐ Dental Blue Option 3 | Please check coverage type and person(s) to be covered:<br>Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family<br>Dental: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family |

| | | |
|---|---|---|
| **Healthy Blue HDHP**<br>$1,500S/$3,000F w/20% Coinsurance<br>☐ BKW 100% contribution<br><br>☐ $5,500S/$11,000F w/0% Coinsurance (C3) | **Dental** (DE)<br>☐ Dental Blue Option 3 | Please check coverage type and person(s) to be covered:<br>Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family<br><br>Dental: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family |

## 3 – Reason for Enrollment/Change

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

___ New Hire ____ COBRA ____ Retirement ____ Loss of Coverage ____ Domestic Partner

____ Open Enrollment ____ Address/Phone Number ____ Last Name ____ Age 65+ ____ Remove Dependent

___ Medicare Eligible / Please indicate reason for Medicare eligibility: ___ Newborn ___ Disability ___ End Stage Renal Disease

____ Add Dependent / Please indicate reason for adding dependent: ___ Adoption ___ Marriage ___ Marital Status Change

## 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 ______________________

Middle Initial ____ Title ________ E-mail Address ______________________

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

Ob/Gyn's Last Name ______________________ Ob/Gyn's First Name ______________________

Are you a Previous Patient of PCP? ____ Yes ____ No

Are you a Previous Patient of Ob/Gyn? ____ Yes ____ No

Mailing Address ______________________ Apt or Suite ____________

City ______________________ State _____ Zip ____________

Work Phone Number _______-______-________/ Home Phone Number ________-________-_______/ Cell Phone Number _______-______-_________

Date of Birth ______________ Gender ____ M _____ F Social Security Number* ________-_______-____________

Marital Status: _____ Single _____ Married _____ Legally Separated _____ Divorced/ Marital Status Event Date ______________

Medicare Number (if applicable) ______________ Part A Effective Date ______________ Part B Effective Date ______________

If Medicare eligible due to ESRD please check type of dialysis: ____ Self administered _____ Facilitated Date started ______________

## 5 – Other Coverage Information

Have you ever been a member of Excellus BlueCross BlueShield? ___ Yes ___ No

**In addition, please provide a copy of your "Certificate of Coverage" from your former dental insurance carrier or employer.**

Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)?

Health?___No ____Yes / Dental? ____ No ____ Yes

If answering "Yes", are you keeping the additional health or dental coverage? Health? ___ No ___ Yes / Dental? ___ No ____ Yes

Who did the other plan cover? ____ Self ____ Spouse ____ Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: ______________ Effective Date ______________ Termination Date ______________

## 6 – Cancellation Information

**Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).**

Subscriber ____ Medical /Reason ______________ Date ______________

____ Dental /Reason ______________ Date ______________

Dependent (list each dependent in section 7)

___ Medical / Reason ______________ Date ______________

___ Dental / Reason ______________ Date ______________

## 7 – Dependent Information

**Please provide all information for each person to be covered.**

Subscriber's Last Name ______________ Subscriber's First Name ______________

Spouse/Domestic Partner Last Name ______________ Spouse/Domestic Partner First Name ______________ M.I. ____

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

Ob/Gyn's Last Name ______________ Ob/Gyn's First Name ______________

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___Male ___ Female

Date of Birth ______________

Social Security Number* ________-______-________

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

Medicare Number (if applicable) ______________ Part A Effective Date ______________ Part B Effective Date ______________

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Dependent's Last Name ______________ Dependent's First Name ______________ M.I. ____

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

Ob/Gyn's Last Name ______________ Ob/Gyn's First Name ______________

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female

Date of Birth ______________

Social Security Number* ________-________-__________

Is your over-age dependent handicapped or disabled? ___ Yes ___ No

(See last page for additional information)

## 8 – Release/Signature

**Subscriber signature required. You must sign and date this form to be eligible for insurance.**

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 or dental 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.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- 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 an out-of-network benefit which 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.
- POINT OF SERVICE (POS)
  I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as Inpatient Facility care.
- (Applies to Dental Only) The certificate or contract for which application is being made may impose a waiting period on member(s) up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

I have thoroughly read, understand and agree to comply with the terms of the Release.

**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**_________________________

## 9 – Additional Dependents

**Please provide all information for each person to be covered.**

Subscriber's Last Name ______________________ Subscriber's First Name ______________________

Dependent's Last Name ______________________ Dependent's First Name ______________________ M.I. ____

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

Ob/Gyn's Last Name ______________________ Ob/Gyn's First Name ______________________

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female Date of Birth ____________________

Social Security Number* _________-_______-__________

Is your over-age dependent handicapped or disabled? ___ Yes ___ No
(See last page for additional information)

## Subscriber Name:____________________________________________

Dependent's Last Name ______ Dependent's First Name ______ M.I. ____

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

Ob/Gyn's Last Name ______ Ob/Gyn's First Name ______

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female

Date of Birth ____________________

Social Security Number* _________-_______-__________

Is your over-age dependent handicapped or disabled? ___ Yes ___ No
(See last page for additional information)

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Dependent's Last Name ______ Dependent's First Name ______ M.I. ____

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

Ob/Gyn's Last Name ______ Ob/Gyn's First Name ______

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

Male ___ Female

Date of Birth ____________________

Social Security Number* _________-_______-__________

Is your over-age dependent handicapped or disabled? ___ Yes ___ No
(See last page for additional information)

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Dependent's Last Name ______ Dependent's First Name ______ M.I. ____

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

Ob/Gyn's Last Name ______ Ob/Gyn's First Name ______

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

____ Male ___ Female

Date of Birth ____________________

Social Security Number* _________-_______-__________

Is your over-age dependent handicapped or disabled? ___ Yes ___ No
(See last page for additional information)

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Dependent's Last Name ______ Dependent's First Name ______ M.I. ____

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

Ob/Gyn's Last Name ______ Ob/Gyn's First Name ______

Are you a Previous Patient of PCP? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female

Date of Birth ______________

Social Security Number* ________-__________________

Is your over-age dependent handicapped or disabled? ____ Yes ____ No
(See last page for additional information)

## Instruction Page

**Reason for Enrollment/Change:** Check the appropriate action in the space provided. 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/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request

**To Cancel an Employee/Subscriber using the Group Enrollment Form:**

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

**Cancel Subscriber Reasons**

Left Employer/No Longer Eligible
Commercial
COBRA Begin Date
COBRA Handicapped/Disabled Date
Transfer to Traditional
Transfer to HMO
Transfer to POS
COBRA End Date
Subscriber Request
Subscriber Deceased
Spouse's Insurance
Medicaid
Medicare

**To Cancel a Dependent using the Group Enrollment Form:**

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

**Cancel Dependent Reasons**

Marriage – when permitted by law
Dependent Over Age
Deceased
COBRA Begin Date
Subscriber Request
Divorce
Medicare

**COVERAGE TYPE** All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

**SUBSCRIBER** If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

**FAMILY MEMBER INFORMATION** If there are more than seven dependents please use an additional form.

*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

**QUALIFIED GUIDELINES:**

- A legal spouse (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- 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 as the following dependents may 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.**

**GROUP EMPLOYER INFORMATION** This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical;/Dental) that is applicable to the employee's request.

**If you have any questions, please contact Customer Service at:**
**1-877-253-4797 Or, visit us at:**
www.excellusbcbs.com

## Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Child Health Plus אדער Managed Medicaid מעמבער, ביטע רופט 1-800-650-4359. אויב איר זענט אן Essential Plan מעמבער, ביטע רופט 1-877-626-9298. אלע אנדערע ביטע רופט 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Child Health Plus أو Managed Medicaid، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ
Child Health Plus یا Managed Medicaid ممبر ہیں تو براہ کرم 1-800-650-4359 پر کال کریں۔ اگر آپ
Essential Plan کے ممبر ہیں تو براہ کریم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 1-
800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa
1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.