



HEALTHY NEW YORK GROUP ENROLLMENT FORM

P.O. Box 22999, Rochester, NY 14692

A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy [] Check if name change [] Check if new address

Please print clearly.

Form section for DESIRED COVERAGE and CHECK PERSON(S) COVERED. Includes options for Add Subscriber (AA), Add Dependent (AB), Change Coverage (AC), and checkboxes for HEALTHY NEW YORK (HN) and HEALTHY NEW YORK HSA (HS). Columns for Self, Spouse & Child(ren) (A), Self & Child(ren) (B), Self & Spouse (C), and Self (D) with MEDICAL checkboxes.

SUBSCRIBER INFORMATION - Are you eligible for Medicare? [] Yes [] No. Includes fields for Social Security #, Sex, Birthdate, Last Name, First, Street, City, State, Zip, Day Phone, E-Mail Address, Reason Code, Cancellation Date, Primary Provider, and OB/GYN Provider.

FAMILY MEMBER INFORMATION - Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled. Repeating table for spouse, dependent, student, etc. with fields for Social Security #, Sex, Birthdate, and Primary Care Physician.

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information. Includes questions about previous insurance and a list of other carriers.

RELEASE - You must sign and date this form to be eligible for insurance. 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...

EMPLOYER INFORMATION (Must be completed by Group Representative) * Dept. # and Employee # is optional.

Form section for EMPLOYER INFORMATION including Coverage, Group/Sub Group #, Chk Digit, Pkg #, Employer Name, Employee Status, and Department #.

Instructions for completing the HEALTHY NEW YORK Group Enrollment Form

DESIRED ACTION Check the appropriate action and indicate the Date(s) in the space provided. An Event Date is the date of 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 60 days of the Event Date. Please see your Group Representative for events that fall outside the 60-day period. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons covered, and Family Member Information section.

Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet - OR -**

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

- check Subscriber (S) Box
- check Product to be cancelled (Medical)
- indicate Reason Code in space provided (See codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

LE - Left Employer/No Longer Eligible	CE - Cobra End Date
SD - Subscriber Deceased	CP - Commercial
SR - Subscriber Request	SB - Spouse's BCBS
CB - Cobra Begin Date	MC - Medicaid
CD - Cobra Disabled Date	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Product to be cancelled (Medical)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Member Name and Member Birthdate

Cancel Dependent Reasons

MA - Marriage	MB - COBRA Begin Date
OA - Dependent Over Age	MR - Subscriber Request
DM - Deceased	DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- Address
- Birthdate
- PCP
- OB/GYN

SUBSCRIBER If you are disabled, see your Group Representative to determine eligibility for OBRA. If eligible, complete the appropriate form.

FAMILY MEMBER AND DOCTOR INFORMATION Use an additional form, if more than four persons.

QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your employer group
 - Unmarried child, natural, adopted or stepchild
 - A full time student (indicate under Relationship)
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.** Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your employer group.

RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate 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 acknowledgement and agreement on behalf of myself and each other person who now or in the future accept 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 understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.
- I understand that this contract is subject to a twelve (12) month waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.
- **HEALTHY NEW YORK**
I understand that all care, including hospital and physician care, must be provided or arranged by the designated primary care physician.

EMPLOYER INFORMATION

This section to be completed and signed by the Employer Group Representative.
Complete only the coverage section (Medical) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:

(585) 454-4810 or 1-800-462-0108;
TTY (585) 454-2845