BlueCross BlueShield of the Rochester Area

Enrollment for Dependent Students

Subscriber Name *(Last, First, Middle)*	Subscriber ID Number	Social Security Number
Address *(No. & Street, City, State, Zip Code)*		
Group Name	Group Number	Subscriber's Birthdate Month / Date / Year
Dependent Student's Name		Student's Birthdate Month / Date / Year
Does this student currently have an individual Health Insurance Contract? ☐ Yes ☐ No		If yes, give contract number
Name of Accredited School ☐ Full time ☐ Part time	Date entered	Expected date of graduation

☑ If current Patient

PCP ID - Office Use Only

Blue Choice Primary Physician _____ Yes ☐ No ☐

OB/GYN _____ Yes ☐ No ☐

☐ Private Office ☐ Wilson 102 ☐ Folsom 103 ☐ Greece 104 ☐ Perinton 105

Parent's Signature Date

B-469 CP (1/93)