



Health Care Enrollment/Change Form

DO NOT USE - MICROFILM ONLY

Instructions on Back. All Dates = mm/dd/yy Check if name change Check if new address Please print clearly.

✓ CHECK DESIRED ACTION	✓ CHECK DESIRED MEDICAL COVERAGE	✓ CHECK PERSON(S) COVERED			
<input type="checkbox"/> Add Subscriber (AA) Date of Hire/Event ___/___/___ Coverage Eff Date ___/___/___	<input type="checkbox"/> Blue Point2 POS A (IN) <input type="checkbox"/> Blue Point2 POS B (NB) <input type="checkbox"/> Blue Point2 POS B No Drug (ND) <input type="checkbox"/> Blue PPO (BP) <input type="checkbox"/> BCBS Comprehensive (CO)	Family (A)	One Parent Family (B)	Two Person (C)	Individual (D)
<input type="checkbox"/> Add Dependent (AB) Date of Event ___/___/___ Coverage Eff Date ___/___/___		<input type="checkbox"/> MEDICAL <input type="checkbox"/> <input type="checkbox"/> DENTAL <input type="checkbox"/> <input type="checkbox"/> VISION <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Change Coverage (AC) Coverage Eff Date ___/___/___	✓ CHECK DESIRED DENTAL COVERAGE				
	<input type="checkbox"/> Dental (DE)				

<input type="checkbox"/> Transfer to COBRA (AD) <input type="checkbox"/> (S)ubscriber <input type="checkbox"/> (M)Dependent <input type="checkbox"/> (D)isabled Date of Event ___/___/___	SUBSCRIBER INFORMATION - Must be completed Social Security # [] [] [] - [] [] [] - [] [] [] [] Sex: <input type="checkbox"/> M <input type="checkbox"/> F Birthdate ___/___/___ Last Name _____ First _____ Street _____ City _____ State _____ Zip _____ Day Phone: [] [] [] [] - [] [] [] [] - [] [] [] [] E-Mail Address: _____ Primary Provider (Last) _____ (First) _____ Current Patient? <input type="checkbox"/> Y <input type="checkbox"/> N OB/GYN Provider (Last) _____ (First) _____ <input type="checkbox"/> Y <input type="checkbox"/> N			
<input type="checkbox"/> Cancel Subscriber (S) <input type="checkbox"/> Cancel Dependent (M) <input type="checkbox"/> (M)edical <input type="checkbox"/> (D)ental Reason Code (see back) _____ Cancellation Date ___/___/___				

FAMILY MEMBER INFORMATION ✓ Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

<input type="checkbox"/> (S)pouse <input type="checkbox"/> Domestic (P)artner <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) (H)disabled <input type="checkbox"/> (F)oster/Grandchild Dependent Last Name (if different) First Name	Coverage Elected <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___	Medical Center <input type="checkbox"/> (W)ilson <input type="checkbox"/> (F)olsom <input type="checkbox"/> (G)reece <input type="checkbox"/> (P)erinton	Primary Care Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N	OB/GYN Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> (F)oster/Grandchild Dependent Last Name (if different) First Name	Coverage Elected <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___	Medical Center <input type="checkbox"/> (W)ilson <input type="checkbox"/> (F)olsom <input type="checkbox"/> (G)reece <input type="checkbox"/> (P)erinton	Primary Care Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N	OB/GYN Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> (F)oster/Grandchild Dependent Last Name (if different) First Name	Coverage Elected <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___	Medical Center <input type="checkbox"/> (W)ilson <input type="checkbox"/> (F)olsom <input type="checkbox"/> (G)reece <input type="checkbox"/> (P)erinton	Primary Care Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N	OB/GYN Physician Last First Current patient? <input type="checkbox"/> Y <input type="checkbox"/> N
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OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.
In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.
Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?
 Yes No Check: Medical and/or Dental Are you keeping this coverage? Yes No
 Check previous insurance company from list below and indicate ID #: _____
 (B) Blue Cross Blue Shield of the Rochester Area, Blue Choice, ViaHealth Plan.
 (O) Other - Blue Cross and Blue Shield Plan (outside of Rochester). Indicate Plan Name: _____
 (C) Other Carrier - Indicate Plan Name: _____

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, 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 have thoroughly read, understand and agree to comply with the terms of the Release on the back.
 Subscriber Signature _____ Date _____

EMPLOYER INFORMATION (Must be completed by RIT Human Resources)

Coverage	Group/Sub Group #	Chk Digit	Pkg #	Employee Status
Medical				<input type="checkbox"/> (A)ctive <input type="checkbox"/> (A) COBRA <input type="checkbox"/> Termination <input type="checkbox"/> (R)etired
Dental				
Rx				

Human Resources Signature _____ Date: _____

Instructions for completing the RIT Health Care Enrollment/Change 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 31 days of the Event Date. Please see your Group Representative for events that fall outside the 31-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 Products to be cancelled (Medical, Dental)
- 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
PC - Preferred Care	SR - Subscriber Request
CP - Commercial	SD - Subscriber Deceased
CB - Cobra Begin Date	SB - Spouse's BCBSRA
CD - Cobra Disabled Date	MC - Medicaid

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent (M) box
- check Products to be cancelled (Medical, Dental)
- 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 | ➤ Medical Center |
|-----------|-------------|-------|----------|------------------|

DESIRED COVERAGE All products may not be applicable to your employer group. Please check with your Group Representative.

SUBSCRIBER If you are retired and Medicare eligible, complete the Medicare Eligible - Group Enrollment Form. 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)
 - A resident in the subscriber's household or the household of an ex-spouse
- **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 any physician, hospital or other medical facility or provider to release to the insurance plan I elected any and all records and information regarding services requested or received for any of the persons listed on the reverse side of this form as members of the insurance plan
- I understand that if I have elected a managed care product, 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 Human Resource Department. 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:

Blue Cross Blue Shield of the Rochester Area (585) 325-3630 or (800) 847-1200