

GROUP ENROLLMENT FORM

Institutions on Back, All Dates = mm/dd/y	P.O. Box 22999, Rochester, NY 14692							NOT USE - INTERNAL PURPOSES ONLY				
Check Desiries Mountain	A nonprofit independent licensee of the BlueCross BlueShield Association Instructions on Back. All Dates = mm/dd/vy							Please print clearly				
Date of blues/bern (AA) Date of blues/bern (AB) Date of blues/be	f											
Date of Event	☐ Add Subscriber (AA) Date of Hire/Event / /	Classic Blue Classic Blue Classic BlueCross (I Classic BlueCross BlueCros	(KC) KA) IlueShield (KB)	☐ BluePoint	t 2 (SF) ice 25 (BZ)	☐ PPO (PN) ☐ Excellus BluePP	O (BP)	Self, Spouse & Child(ren)	Self & Child(ren)	Self & Spouse	Self	
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Date of Event	1	Social Security#										
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Reason Code (see back)		Blue Choice n	nembers must sele	ect a Medi	cal Center or Pr	imary Care Phys	ician (PCP). Fe	males may s	elect an Ol	/Gyn.		
Cancellation Date												
FAMILY MEMBER INFORMATION Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled. Glypouse Glypendent Sludent(T) Social Security # Sex Birthdate Medical Center Glypendent	1	(100)							_ OY		- 1	
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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)? Ores No Check: Medical and/or Dental Are you keeping this coverage? Person for No No Check: Medical and/or Dental Are you keeping this coverage? No No Check: Medical and/or Dental Are you keeping this coverage? No No Check: Medical and/or Dental Are you keeping this coverage? No No Check: Medical and/or Dental Are you keeping this coverage? No No Check: Medical and/or Dental Are you keeping this coverage? No	☐ (H)disabled ☐ (F)oster/Grandchild Dependent ☐ Other ☐ Other ☐ Clast Name (if different) First Name			I ам I		☐ (F)olsom						
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Other - BlueCross BlueShield Plan (outside of Rochester). 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 Group Administrator) *Deductible Amt., Dept. # and Employee # is optional. Was the employee subject to a waiting period before enrolling in your employer health plan? Yes No	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)? Office Yes Office											
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ii yes, what was the start date / / and end date / /	Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ Yes ☐ No If yes, what was the start date / / and end date / /											

Group/Sub Group#

Chk digit

Pkg#

Deductible Amount*

Coverage

Medical

Dental

Vision

0 0 Employee Status

0 0 Department #*

Employer Name

. 0 0 Group Rep Signature/Date

☐ (A)Active ☐ (A)COBRA ☐ (A)Cancellation ☐ (R)etired

Employee #*