Excellus | National strength. Local focus. Individual care.™

A nonprofit independent licensee of the Blue Cross Blue Shield Association

FOR INTERNAL USE ONLY

HIOS ID#: 78124NY0880003-00

EC: IIIS

Individual & Family Health Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included

Section 1: Plan options

(A) Plan Options (You may only select one)	(B) Dependent Coverage to Age 29	(C) Child Only (Only available if you select a Standard plan option in column A. If selected your child will be covered until age 21)
☐ Platinum Standard	☐ NO	☐ NO

Section 2: Pediatric dental coverage YES

Please answer the following questions:

1.) Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health-certified stand-alone dental plan offered outside of the NY State of Health?

☐Yes ☐No

2.) If yes, please provide the name of the company issuing the stand-alone dental coverage

_____

If no, we will provide you with coverage of the pediatric dental essential health benefit.

- At an additional charge

Section 3: What do you need to do?

☐Enroll in a new plan ☐Add dependent(s) to current coverage ☐Cancel coverage

☐Change current coverage ☐Remove a dependent ☐Name or address change

Section 4: If enrolling in a new plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren) ☐Self & Spouse/Domestic Partner ☐Family ☐Child Only

Effective Date: ___/___/____

Section 5: If canceling coverage, who are you canceling coverage for?

☐Self Only ☐Self & Child (ren) ☐Self & Spouse/Domestic Partner ☐Family ☐Child Only

Cancelation Date _____

Why are you canceling coverage?

☐Subscriber's request ☐Coverage through spouse ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage

Section 6: Special Enrollment Period

If you are applying outside of the annual Open Enrollment Period, please check one of the events below that applies to you. The Special Enrollment Period begins on the date of the event checked and continues for 60 days.

☐Loss of coverage ☐Marriage ☐Birth ☐Adoption ☐Domestic Partnership ☐Death ☐Pregnancy ☐Domestic Violence
☐A move in or out of service area ☐Divorce, annulment or legal separation ☐Dependent reaches maximum age of coverage
☐Change to new employer that does not offer insurance ☐Change in employment status ☐Other_____

Date of Event _____

Section 7: Your Information (REQUIRED)

_____ Subscriber ID# _____

Last Name First Name MI (For changes and cancellations)

Social Security #**_____ Birthdate ___/___/___ Sex: M F

_____

Street Address City State Zip

_____

Billing Address (if different) City State Zip

_____ Would you like to receive emails about health & wellness? Yes No

Phone Email

Section 8: Third party administrator must complete this section (Broker, Agent, Internal Sales, and Certified Application Counselor (CAC) – If a broker, license # for the agency must be completed to be eligible for commission)

Name of Broker/Agent/CAC/Person assisting _____

Agency Name (if applicable)_____

Agency License # (if applicable) _____

Agency Tax ID (if applicable) _____

Section 9: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____

Sex: M F Birthdate ___/___/___

_____ _____

Last Name (if different) First Name MI Social Security #**

Section 9: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____

Sex: M F Birthdate ___/___/___

_____ _____

Last Name (if different) First Name MI Social Security #**

callid_' . 2018 . '_tmp_independent_application.pdf

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____
Sex: M F Birthdate ___/___/___

_____ _____
Last Name (if different) First Name MI Social Security #**

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____
Sex: M F Birthdate ___/___/___

_____ _____
Last Name (if different) First Name MI Social Security #**

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child ☐Child Only ☐Other_____
Sex: M F Birthdate ___/___/___

_____ _____
Last Name (if different) First Name MI Social Security #**

Section 10: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in Medicare or Medicaid? ☐Yes ☐No
If yes, are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage cancel? __/__/__
Policyholder's name _____ ID# _____ Effective Date: ___/___/____
Did the insurance cover ☐Insured ☐Insured and family

Section 11: Release – You must sign and date this form to be eligible for health insurance.

Pursuant to federal rules that implement the Affordable Care Act, individual health insurance policies must be written on a calendar year basis. This means that if your effective date of coverage is a date later than January 1 of that year, the initial term of coverage for your policy will be for less than a full year and will end on December 31 of that same year. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract 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 accepts 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 hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

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

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**_____

Instructions for completing Individual & Family Health Insurance Application

Section 1

Column A – Select one plan option only

Column B – Select this option if you would like to purchase additional coverage for dependents age 26 – 29. Dependents will be covered until end of the month the Dependent turns 30 years of age (cannot be selected in conjunction with a Child-Only plan)

Column C – Select a child only plan if you need coverage for a child or children up to age 21.

Section 2

Indicate whether you have stand-alone pediatric dental coverage through a NY State of Health plan or through a different insurance company. If your coverage is through another company, please include the name of the company. If you indicate that you do not have a stand-alone pediatric dental plan through a different insurance company; understand that we will automatically enroll you in the medical plan you selected that includes pediatric dental care for an additional cost.

Section 3

Select the box that describes what you need to do regarding health insurance coverage.

Section 4

Select the box that describes who you need coverage for. Please complete section 7 if you select any box other than self only.

Section 5

If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 6

There are certain life changes that make you eligible for a Special Enrollment Period (SEP) such as having a baby, getting married or your coverage under another plan is ending. Select the event that applies to you and include the date of the event. You may be required to provide documentation of certain events. *Please contact our dedicated Insurance Advisors at 1-888-264-7792 for a list of documentation required.

Section 7

The entire section is REQUIRED to be completed by the subscriber. For child only plans, the parent or guardian's information is REQUIRED in this section.

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

Section 8

This section is to be completed by the Third Party Administrator who may be assisting you with your enrollment process. A third party administrator can be an authorized agent or broker and to the extent permitted by the Federal and State law and regulation, any other third party assistors. If you are not working with a Third Party Administrator, you can disregard this section.

Section 9

Please include information about all the people for whom you would like coverage. Use an additional application if more than five people need coverage. There are additional eligibility and documentation requirements for coverage of dependents noted with an asterisk (*) below. Qualified guidelines for coverage include:

- A legal spouse*/domestic partner* (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Dependent under the age of 26 – Natural, adopted* or stepchild
- Child (ren) Only coverage is available for children up to age 21
- Disabled Dependents* over the dependent age
- Dependents by legal guardianship*
- *Please contact our dedicated Insurance Advisors at 1-888-264-7792 or visit our website Excellusbcbs.com for information and any required form(s). Eligibility Requirements are outlined in the Member Contract.

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

Section 10

Please include accurate information in this section. This could affect the processing of your application and/or claims. Medicaid is a public aid program for those with a limited income. This is not the same as Medicare.

If you are Medicare eligible and enrolled in Medicare Part A and/or Medicare Part B, do not complete this application. Please contact one of our dedicated Insurance Advisors at 1-888-264-7792 for the Supplemental Medicare Eligible Enrollment Form or a Medicare Advantage plan enrollment application

YOUR PREMIUM PAYMENT MUST BE INCLUDED WITH THE APPLICATION

Please mail application and payment to:

Excellus BlueCross BlueShield
P.O. Box 22999
Rochester, NY 14692

If you have questions, please contact our dedicated Insurance Advisors at 1-888-264-7792
Learn about exclusive member benefits at ExcellusBCBS.com/FindAPlan

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, please refer to the enclosed document for ways to reach us.

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.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495