

FLASHP GROUP ENROLLMENT FORM

P.O. Box 21146, Eagan, NRV SS121-0146 A nonprofit Independent Bossese of the BlueCross BlueShletd Association

VTA

DO NOT	USE - FOR INSERNAL PURPOSES ONLY
HIOS ID# EC	

1 - Group Employer Informat		PLEASE PRINT CLEARLY
This section should be comp	leted by the Group Benefits Ac	iministrator.
This application cannot be pr	ocessed without this informat	ion and a signature.
Please use blue or black ink, print one		Subscriber Status:
Group # 00044320	Subgroup # Class# A 100	Active Retired COBRA Cancelled
	7100	Please Indicate reason for COBRA:
		Left Employ/Retirement Death of Spouse
Victor CSD Association/Chamber Name (if applicable)		Divorce/Legal Separation Dependent Reached Max Age Other
ASSOCIATION VIOLENCE INCIDENTAL (II APPRICE	inio)	VIII
		Effective Date COBRA Effective Date
Group Administrator Signature/Date		
X		Hire/Rehire Date Retired Effective Date
Dental Group # 4523	Subgroup # 502	
Subscriber Name		
· · · · · · · · · · · · · · · · · · ·		
	period before enrolling in your employ	
it yes, what was the start date:	and end date	
Selection	THE RESERVE OF THE PARTY OF THE	
Please use blue or black ink,	print one character per box. (Check applicable plan(s).
Blue Point 2 \$15/\$15 (BP2Select)	Dental	Please check coverage type and person(s) to be covered:
\$5/\$20/\$35 Rx (EG)	□ Dental Blue Option 3 (DJ)	MEDICAL: □ Single □ Two Person □ Family No Spouse □ Famil
, ,		
		DENTAL: □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
Blue Point 2 \$20/\$20 (BP2Value)	Dental	Please check coverage type and person(s) to be covered:
3 \$10/\$25/\$40 Rx (ET)	- Dontal Plus Ontion 2 (D.I)	
3 \$10/\$25/\$40 PX (E1)	□ Dental Blue Option 3 (DJ)	MEDICAL: □ Single □ Two Person □ Family No Spouse □ Famil
		DENTAL: □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
lealthy Blue	Dental	Please check coverage type and person(s) to be covered:
•		
3 \$25 PCP/\$40 Specialist (A2)	□ Dental Blue Option 3 (DJ)	MEDICAL: □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
		DENTAL: □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
	Dental	Please check coverage type and person(s) to be covered:
Signature HDHP High-Option	Pelital	
\$1,500 Single/\$3,000 Family With 20% Coinsurance	□ Dental Blue Option 3 (DJ)	MEDICAL: Single Emp/Spouse Emp/Child(ren) Family
		DENTAL: Single Emp/Spouse Emp/Child(ren) Family
OPEN ENROLLMENT EFF JAN 1 ^{ST}		*I understand that a Family deductible is applied for a health plan

	enrollment or	change.		
New Hire COBRA	_ Retirefnent 🔹	Loss of C	overage	Domestic Partner
Open Enrollment Address/Phone Number	_ Last Name _	Age 65+	Remove Depe	ndent
Medicare Eligible / Please indicate reason for Medicare	eligibility:	Newborn	Disability	End Stage Renal Disease
Add Dependent / Please indicate reason for adding d	ependent:	Adoption	_Marriage	Marital Status Change
- Subscriber Information		Or and the second		
lease complete both sides of this application he subscriber signature is required in order	1. to process the	application.		
ubscriber's Last Name		Subscriber	s First Name	
iddle Initial Title E-mail Address				
imary Care Physician's Last Name		Primary Care Phy	sician's First Name	
b/Gyn's Last Name		Ob/Gyn's First N	ame	
re you a Previous Patient of PCP?	re you a Previous P	Patient of Ob/Gyn	?	
	Yes I			
Mailing Address	SPECIAL DEPOSIT S		Apt or Suite	
ity		State	Zip	
fork Phone Number Home Pho	ne Number	Cell Pho	ne Number	
	- 1	•	•	
ate of Birth Gender So	cial Security Numb	er*		
M F	-	-	_	
Aarital Status: Single Married Le			Aarital Stalus Event	Date
fedicare Number (if applicable) Part	A Effective Date	Part B Ef	ective Date	
			· · · · · · · · · · · · · · · · · · ·	
Medicare eligible due to ESRD please check type of dialy	ysis: Self adr	ministered	_ Facilitated Date	started
		of Franklin Olive	Ones Dharchield?	Van Bla
- Other Coverage Information Have you ev	rer been a member	of Excellus Blue	Cross BlueShield?	Yes No ntal insurance carrier or
5 – Other Coverage Information Have you even addition, please provide a copy of your "Comployer.	ertificate of Co	overage" from	your former de	ntal insurance carrier or
addition, please provide a copy of your "C	ertificate of Co	overage" from	your former de	ntal insurance carrier or
n addition, please provide a copy of your "C mployer. re you or any member of your family enrolled in any other	ertificate of Co	overage" from	your former de	ntal insurance carrier or
n addition, please provide a copy of your "C mployer. re you or any member of your family enrolled in any other lealth?NoYes / Dental? No Yes	ertificate of Co	overage" from	your former de	ntal insurance carrier or Medicald)?
n addition, please provide a copy of your "C imployer. Ite you or any member of your family enrolled in any other lealth?NoYes / Dental?NoYes answering "Yes", are you keeping the additional health o	r health or dental in r dental coverage?	surance policy (in the Health? No	your former de	Medicaid)? No Yes
n addition, please provide a copy of your "C	r health or dental in r dental coverage?	surance policy (in the Health? No	your former de	Medicaid)? No Yes
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n addition, please provide a copy of your "C mployer. re you or any member of your family enrolled in any other ealth?NoYes / Dental?NoYes answering "Yes", are you keeping the additional health of who did the other plan cover?SelfSpouse_Blher insurance carrier name: Other insurance name of policyholder: Included the content of the	r health or dental in r dental coverage? Children	surance policy (in Health? No	your former de	Medicaid)? P. No Yes ermination Date
n addition, please provide a copy of your "Comployer. Ire you or any member of your family enrolled in any other Itealth?NoYes / Dental?NoYes Itealthapper answering "Yes", are you keeping the additional health of the other plan cover?SelfSpouse _	r health or dental in r dental coverage? Children Ef	surance policy (in Health? No fisculve Date	your former de concluding Medicare or Yes / Denta	Medicaid)? P. No Yes ermination Date
n addition, please provide a copy of your "C imployer. Ire you or any member of your family enrolled in any other lealth?NoYes / Dental?NoYes I answering "Yes", are you keeping the additional health of Who did the other plan cover? Self Spouse Other insurance carrier name: Other insurance name of policyholder: Folicy ID Number: The Cancellation Information Please Indicate who is being cancelled and the subscriber Medical /Reason	r health or dental in r dental coverage? Children Ef	surance policy (in Health? No ffective Date	your former de reluding Medicare or Yes / Denta	Medicaid)? Programme carrier or Medicaid)? Programme Yes Province Medicaid (1)? Programme Yes Province Medicaid (1)?
n addition, please provide a copy of your "Comployer. Ire you or any member of your family enrolled in any other leath?NoYes / Dental?NoYes answering "Yes", are you keeping the additional health of the other plan cover? SelfSher insurance carrier name: Other insurance name of policyholder: Other insurance name of policyholder: Ocicy ID Number:	r health or dental in r dental coverage? Children Ef	surance policy (in Health? No ffective Date	your former de reluding Medicare or Yes / Denta	Medicald)? Possible Property No Yes Promination Date In page 4).
n addition, please provide a copy of your "C imployer. Ire you or any member of your family enrolled in any other lealth?NoYes / Dental?NoYes answering "Yes", are you keeping the additional health of Who did the other plan cover?SelfSpouse_ Other insurance carrier name: Other insurance name of policyholder: Colicy ID Number: In Cancellation Information Please Indicate who is being cancelled and to Subscriber Medical /Reason Dental /Reason	r health or dental in dental coverage? Children Ef	surance policy (in the state) Health? No section (your former dendling Medicare or Yes / Denta Teason listing of Date Date	Medicaid)? Programme carrier or Medicaid)? Programme Yes Province Medicaid (1)? Programme Yes Province Medicaid (1)?
n addition, please provide a copy of your "Comployer. Ire you or any member of your family enrolled in any other Is answering "Yes", are you keeping the additional health of the other plan cover? Self Spouse Other insurance carrier name: Other insurance name of policyholder:	r health or dental in dental coverage? Children	surance policy (in Health? No iffective Date	your former de caluding Medicare or Yes / Denta Treason listing of Date Date	mtal insurance carrier or Medicaid)? Possible Properties of the carrier or the

Please provide all Information for Subscriber's Last Name	and the sour to ne covere		de Eiret Nama	E-Warren	
Subscriber's Last Name		Subscriber's First Name			
Spouse, Last Name		Spouse	First Name	78	M.I.
Primary Care Physician's Last Name		Primary Ca	re Physician's First Name		
Ob/Gyn's Last Name		Ob/Gyn's	First Name		
Are you a Previous Patient of PCP?	Are you a Pr	evious Pati	ent of Ob/Gyn?		
Yes No	Yes	No			
Male Date of Birth	Social Security Number	•	Are you enrolling as	s a Domestic Pa	rtner?
Female	Part A Effective Da	te	Part B Effective Date		
Dependent's Last Name		Danandar	nt's First Name		M.I.
Departion 3 Last Hamo		Dopolisoi	K o i nat Hang		1914 (+
Primary Care Physician's Last Name		Primary Co	ere Physician's First Name		
Ob/Gyn's Last Name		Ob/Gyn's First Name			
Are you a Previous Patient of PCP?	Are you a P	revious Pa	tient of Ob/Gyn?		
Yes No	Yes	No			
Male Date of Birth	Social Security Number*	k	s your over-age dependent handica	oped or disabled	?Y
Female		_	(See last page for addition	al information)	No
Dependent's Last Name		Depende	nt's First Name		M.I.
Primary Care Physician's Last Name		Primary C	are Physician's First Name		_
Ob/Gyn's Last Name	1177	Ob/Gyn's	First Name	O. 10	
Are you a Previous Patient of PCP?	Are you a F	revious Pa	lient of Ob/Gyn?		
Yes No	Yes	No			
Male Date of Birth	Social Security Number*	1	s your over-age dependent handica	pped or disabled	j? Y

Subscriber Name:	N. P. BEZE			
Dependent's Last Name Primary Care Physician's Last Name Ob/Gyn's Last Name		Dependent's First Name	M,I.	
		Primary Care Physician's First Name Ob/Gyn's First Name		
Yes No	Yes No			
Male Dale of Birth Female	Social Security Number*			
Dependent's Last Name		Dependent's First Name	M.I.	
Primary Care Physician's Last Name		Primary Care Physician's First Name		
Ob/Gyn's Last Name		Ob/Gyn's First Name		
Are you a Previous Patient of PCP?	Are you a Previous	Patient of Ob/Gyn?		
Yes No	Yes No			
Male Date of Birth	Social Security Number ^a	Is your over-age dependent handicapped or disabled	? Yes	
Female		(See last page for additional information	n) No	
Dependent's Last Name		Dependent's First Name	M.I.	
Primary Care Physician's Last Name		Primary Care Physician's First Name		
Ob/Gyn's Last Name Are you a Previous Patient of PCP?	•	Ob/Gyn's First Name s Patient of Ob/Gyn?		
Yes No	Yes No			
Male Date of Birth	Social Security Number*	ls your over-age dependent handicapped or di		
Female		(See last page for additional informal	tion) No	
Dependent's Last Name		Dependent's First Name	M.I.	
Primary Care Physician's Last Name		Primary Care Physician's First Name		
Ob/Gyn's Last Name		Ob/Gyn's First Name		
Are you a Previous Patient of PCP?	Are you a Previou	s Patient of Ob/Gyn?		
Yes No	Yes No			
Male Date of Birth	Social Security Number*	is your over-age dependent handicapped or disa	abled? Ye	
Female		(See last page for additional information	on) No	

8 – Release/Signature					
Subscriber signature required	d. You must sign and date ti	ils form to be eligible for insurance.			
RELEASE			9		
	I my eligibie dependents, if any, unde				
In the event that a premium contr I authorize my employer to deduce	ibution is required of me, I agree to p It from my payroli such applicable am	ay the premium amounts applicable to the contract of the premit them to Excellus BlueCross Blue	under which I am covered. Shleid.		
	alf of a minor, the responsible party n				
 By accepting this contract, I grant insurance carrier acting as my pri 		ueShield to submit charges to and/or recover paymon	ent from any other		
I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.					
	-	and complete to the best of my knowledge.			
PREFERRED PROVIDER ORGA	ANIZATION (PPO)				
medical providers who participate participate with the PPO. I under	e with the PPO and an out-of-network	is comprised of an in-network benefit that is depend benefit which provides coverage for services of me rides the highest level of coverage under the plan.	dent on the utilization of dical providers who do not		
> POINT OF SERVICE (POS)					
the in-network benefit provides the	he highest level of coverage under the	n two benefit levels: In-network or out-of-network ber s plan and that I must choose a Primary Care Provid red, obtain prior approval for certain services such a	er (PCP) to provide my		
DIKIMIY CAMB, UYOTSOO INY UUROI I	edificate or contract for which appli-	ation is being made may impose a waiting period	on member(s) up to		
(Applies to Dental Only) The c twelve (12) months for preexist certificate or contract documen	ing conditions, subject to the provis t will describe any applicable waiting		ge requirements. The		
(Applies to Dental Only) The c twelve (12) months for preexist certificate or contract documen I have thoroughly read, understandary person who knowingly and or statement of claim containing concerning any fact material this	ing conditions, subject to the provis t will describe any applicable waiting d and agree to comply with the ter with intent to defraud any insu- g any materially false information	g periods. ms of the Release. rance company or other person files an app in, or conceals for the purpose of misleading grance act, which is a crime, and shall also b	ication for insurance		
(Applies to Dental Only) The contwelve (12) months for preexist certificate or contract document. I have thoroughly read, understandary person who knowingly and or statement of claim containing concerning any fact material the penalty not to exceed \$5,000 and	ing conditions, subject to the provis t will describe any applicable waiting d and agree to comply with the ter with intent to defraud any insu- g any materially false information	g periods. ms of the Release. rance company or other person files an applian, or conceals for the purpose of misleading arance act, which is a crime, and shall also be or each such violation.	ication for insurance		
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 (Applies to Dental Only) The continuous (12) months for preexist certificate or contract document. I have thoroughly read, understand Any person who knowingly and or statement of claim containing concerning any fact material this penalty not to exceed \$5,000 and Subscriber Signature 9 - Additional Dependents Please provide all information Subscriber's Last Name 	ing conditions, subject to the provisit will describe any applicable waiting and agree to comply with the term with intent to defraud any insugany materially false information and the stated value of the claim to the stated value of the claim to the for each person to be covered.	ms of the Release. rance company or other person files an appin, or conceals for the purpose of misleading trance act, which is a crime, and shall also be or each such violation. Date Date Dependent's First Name	ication for insurance g, information e subject to a civil		
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 (Applies to Dental Only) The continuous (12) months for preexist certificate or contract document. I have thoroughly read, understand Any person who knowingly and or statement of claim containing concerning any fact material this penalty not to exceed \$5,000 and Subscriber Signature. 9 - Additional Dependents. Please provide all information Subscriber's Last Name. Dependent's Last Name. Primary Care Physician's Last Name. Ob/Gyn's Last Name. 	ing conditions, subject to the provis t will describe any applicable waitin d and agree to comply with the ter with intent to defraud any insu g any materially false informatio ereto, commits a fraudulent insu d the stated value of the claim to me for each person to be cove	ms of the Release. rance company or other person files an applian, or conceals for the purpose of misleading trance act, which is a crime, and shall also be or each such violation. Date Date Dependent's First Name Primary Care Physician's First Name Ob/Gyn's First Name	ication for insurance g, information e subject to a civil		
(Applies to Dental Only) The continuous twelve (12) months for preexist certificate or contract document. I have thoroughly read, understand Any person who knowingly and or statement of claim containing concerning any fact material this penalty not to exceed \$5,000 and Subscriber Signature. 9 — Additional Dependents Please provide all information Subscriber's Last Name Dependent's Last Name Primary Care Physician's Last Name Ob/Gyn's Last Name Are you a Previous Patient of PCP? Yes No	ing conditions, subject to the provis t will describe any applicable waitin d and agree to comply with the ter with intent to defraud any insu g any materially false informatio ereto, commits a fraudulent insu d the stated value of the claim to me for each person to be cove Are you a Previo — Yes — No	ms of the Release. rance company or other person files an applian, or conceals for the purpose of misleading trance act, which is a crime, and shall also be for each such violation. Date Date Dependent's First Name Primary Care Physician's First Name Ob/Gyn's First Name	ication for insurance g, information be subject to a civil		
Applies to Dental Only) The contwelve (12) months for preexist certificate or contract document have thoroughly read, understant Any person who knowingly and or statement of claim containing concerning any fact material this penalty not to exceed \$5,000 and Subscriber Signature 9 — Additional Dependents Please provide all Information Subscriber's Last Name Dependent's Last Name Primary Care Physician's Last Name Ob/Gyn's Last Name	ing conditions, subject to the provis t will describe any applicable waitin d and agree to comply with the ter with intent to defraud any insu g any materially false informatic ereto, commits a fraudulent insu d the stated value of the claim to en for each person to be cove	ms of the Release. rance company or other person files an applian, or conceals for the purpose of misleading trance act, which is a crime, and shall also be or each such violation. Date Date Dependent's First Name Primary Care Physician's First Name Ob/Gyn's First Name	ication for insurance g, information e subject to a civil M.I. ed or disabled? Yes		