Excellus

P.O. Box 21148, Eagan, MN 55121-0148
A nonprofit independent licensee of the BlueCross BlueShield Association

FLASHP
GROUP ENROLLMENT FORM

VTA

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#_____
EC_____

PLEASE PRINT CLEARLY

Instructions on last page. All Dates = mm/dd/yy

1 – Group Employer Information

This section should be completed by the Group Benefits Administrator.
This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

Group # 00044320 Subgroup # 0601 Class# A100

Employer Name: Victor CSD

Association/Chamber Name (if applicable):

Group Administrator Signature/Date: X

Dental Group # 4523 Subgroup # 502

Subscriber Status:

___ Active ___ Retired ___ COBRA ___ Cancelled

Please indicate reason for COBRA:

___ Left Employ/Retirement ___ Death of Spouse
___ Divorce/Legal Separation ___ Dependent Reached Max Age
___ Other _____

Effective Date _____ COBRA Effective Date _____

Hire/Rehire Date _____ Retired Effective Date _____

Subscriber Name: _____

Was the employee subject to a waiting period before enrolling in your employer health plan? ___ No ___ Yes

If yes, what was the start date: _____ and end date _____

2 – Subscriber Plan Selection

Please use blue or black ink, print one character per box. Check applicable plan(s).

Blue Point 2 $15/$15 (BP2Select) □ $5/$20/$35 Rx (EG)	**Dental** □ Dental Blue Option 3 (DJ)	**Please check coverage type and person(s) to be covered:** **MEDICAL:** □ Single □ Two Person □ Family No Spouse □ Family **DENTAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
Blue Point 2 $20/$20 (BP2Value) □ $10/$25/$40 Rx (ET)	**Dental** □ Dental Blue Option 3 (DJ)	**Please check coverage type and person(s) to be covered:** **MEDICAL:** □ Single □ Two Person □ Family No Spouse □ Family **DENTAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
Healthy Blue □ $25 PCP/$40 Specialist (A2)	**Dental** □ Dental Blue Option 3 (DJ)	**Please check coverage type and person(s) to be covered:** **MEDICAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family **DENTAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family
Signature HDHP High-Option □ $1,500 Single/$3,000 Family With 20% Coinsurance ****OPEN ENROLLMENT EFF JAN 1ST****	**Dental** □ Dental Blue Option 3 (DJ)	**Please check coverage type and person(s) to be covered:** **MEDICAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family **DENTAL:** □ Single □ Emp/Spouse □ Emp/Child(ren) □ Family ***I understand that a Family deductible is applied for a health plan with 2 or more individuals.**

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

___ New Hire ____ COBRA ____ Retirement ____ Loss of Coverage ____ Domestic Partner

____ Open Enrollment ____ Address/Phone Number ____ Last Name ____ Age 65+ ____ Remove Dependent

___ Medicare Eligible / Please indicate reason for Medicare eligibility: ___ Newborn ___ Disability ___ End Stage Renal Disease

____ Add Dependent / Please indicate reason for adding dependent: ___ Adoption ___ Marriage ___ Marital Status Change

4 – Subscriber Information

Please complete both sides of this application.
The subscriber signature is required in order to process the application.

Subscriber's Last Name _____ Subscriber's First Name _____

Middle Initial ____ Title ____ E-mail Address _____

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? ____ Yes ____ No

Are you a Previous Patient of Ob/Gyn? ____ Yes ____ No

Mailing Address _____ Apt or Suite _____

City _____ State ____ Zip _____

Work Phone Number _____ Home Phone Number _____ Cell Phone Number _____

Date of Birth ____/____/____ Gender ____ M ____ F Social Security Number* ____-____-____

Marital Status: _____ Single _____ Married _____ Legally Separated _____ Divorced/ Marital Status Event Date _____

Medicare Number (if applicable) _____ Part A Effective Date _____ Part B Effective Date _____

If Medicare eligible due to ESRD please check type of dialysis: _____ Self administered _____ Facilitated Date started _____

5 – Other Coverage Information

Have you ever been a member of Excellus BlueCross BlueShield? ___ Yes ___ No

In addition, please provide a copy of your "Certificate of Coverage" from your former dental insurance carrier or employer.

Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)?

Health?___No ____Yes / Dental? ____ No ____ Yes

If answering "Yes", are you keeping the additional health or dental coverage? Health? ___ No ___ Yes / Dental? ___ No ____ Yes

Who did the other plan cover? ____ Self ____ Spouse ____ Children

Other insurance carrier name: _____

Other insurance name of policyholder: _____

Policy ID Number: _____ Effective Date _____ Termination Date _____

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ____ Medical /Reason _____ Date _____

____ Dental /Reason _____ Date _____

Dependent (list each dependent in section 7)

___ Medical / Reason _____ Date _____

___ Dental / Reason _____ Date _____

7 – Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name _____ Subscriber's First Name _____

Spouse Last Name _____ Spouse 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? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female Date of Birth _____

Social Security Number* _____-_____-_____

Are you enrolling as a Domestic Partner? ___ Yes ___ No

Medicare Number (if applicable) _____

Part A Effective Date _____

Part B Effective Date _____

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? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female Date of Birth _____

Social Security Number* _____-_____-_____

Is your over-age dependent handicapped or disabled? ___ Yes ___ No

(See last page for additional information)

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? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female Date of Birth _____

Social Security Number* _____-_____-_____

Is your over-age dependent handicapped or disabled? ___ Yes ___ No

(See last page for additional information)

Subscriber Name:_____

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? ___ Yes ___ No | Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female | Date of Birth _____ | Social Security Number* _____-_____-_____ | Is your over-age dependent handicapped or disabled? ___ Yes (See last page for additional information) ___ No

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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? ___ Yes ___ No | Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

Male ___ Female | Date of Birth _____ | Social Security Number* _____-_____-_____ | Is your over-age dependent handicapped or disabled? ___ Yes (See last page for additional information) ___ No

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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? ___ Yes ___ No | Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

____ Male ___ Female | Date of Birth _____ | Social Security Number* _____-_____-_____ | Is your over-age dependent handicapped or disabled? ___ Yes (See last page for additional information) ___ No

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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? ___ Yes ___ No | Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female | Date of Birth _____ | Social Security Number* _____-_____ | Is your over-age dependent handicapped or disabled? ____ Yes (See last page for additional information) ____ No

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- 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.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**
  I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- **POINT OF SERVICE (POS)**
  I understand that the Point of Service (POS) plan provides services on two benefit levels: in-network or out-of-network benefits. I understand that the in-network benefit provides the highest level of coverage under the plan and that I must choose a Primary Care Provider (PCP) to provide my primary care, oversee my other health care services, and, when required, obtain prior approval for certain services such as inpatient Facility care.
- (Applies to Dental Only) The certificate or contract for which application is being made may impose a waiting period on member(s) up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

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

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**_____

9 – Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name _____ Subscriber's First Name _____

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? ___ Yes ___ No

Are you a Previous Patient of Ob/Gyn? ___ Yes ___ No

___ Male ___ Female Date of Birth _____

Social Security Number* _____-_____-_____

Is your over-age dependent handicapped or disabled? ___ Yes ___ No (See last page for additional information)