BlueCross BlueShield of Western New York

Community Blue • Traditional Blue

PO Box 80 • Buffalo, New York 14240-0080

Thank you for choosing BlueCross BlueShield of Western New York to provide your healthcare coverage. We look forward to having you as a member.

To enroll, you need to complete the attached Membership Enrollment Application and Change Form. We've included some brief instructions about how to complete this form. Please remember to **print using blue or black ink only, fill in all circles completely, and print one character per box when writing**. This will enable us to process your application timely and accurately.

At BlueCross BlueShield of Western New York, we are continuously working to provide you with quality care and service. We'd like to share with you some of the ways we do this:

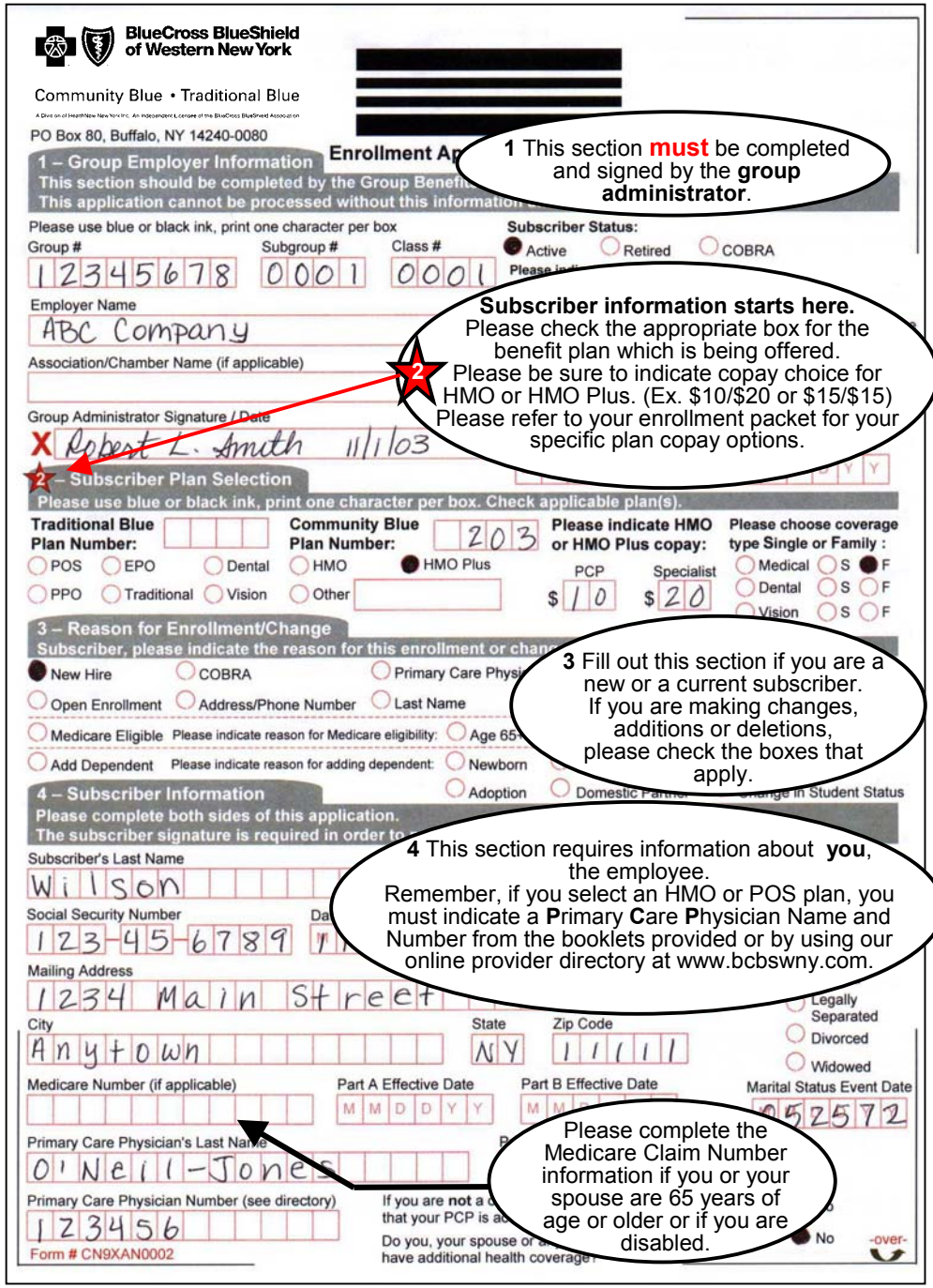
- ✓ Our Concierge Service Program provides members with complete, comprehensive service. Our Customer Service Representatives are available to assist you in any way – answering benefit questions, looking up claims status or helping you to transfer your prescriptions to one of our participating pharmacies.

  When you call about a claim issue, we'll look for other similar claims to make sure they have also been properly resolved. If you are having difficulty resolving an issue with a provider's office, we'll offer to call the provider for you. We review the reasons customers call us to determine what we can do to fix the root causes of the problem, so that other customers won't experience the same problem. Like a concierge in a four star hotel, we go above and beyond, so you know the situation will be taken care of with just one phone call.
- ✓ Members have access to health plan information 24 hours a day through our **web site at** www.bcbswny.com. While at the site, you can review the different health plans we offer; locate a provider who participates with your health plan; or search our drug formulary for quality, cost-effective medications.
- ✓ You can also use the *Click & Comment* feature of our web site to contact us day or night — whenever it's convenient for ***you***. Simply click on the *Click & Comment* logo and you can provide feedback, ask a question or request information. We know you want answers fast, so a representative will respond to you within one business day.
- ✓ Our commitment to service can also be seen in our full certification from Customer Operations Performance Center, Inc. (COPC), an international mark of customer service excellence. Leading international firms such as Microsoft, Motorola, LL Bean and ClientLogic use COPC standards and we are proud to be ***the only local health plan to achieve this certification.*** COPC is 100% focused on making it easier for our customers to contact us and receive immediate resolutions when they have questions or need help.

Thank you again for choosing BlueCross BlueShield of Western New York!

Instructions for Group Enrollment/Change Form

Please remember to print **using blue or black ink *only*, fill in all circles completely, and print one character per box.**



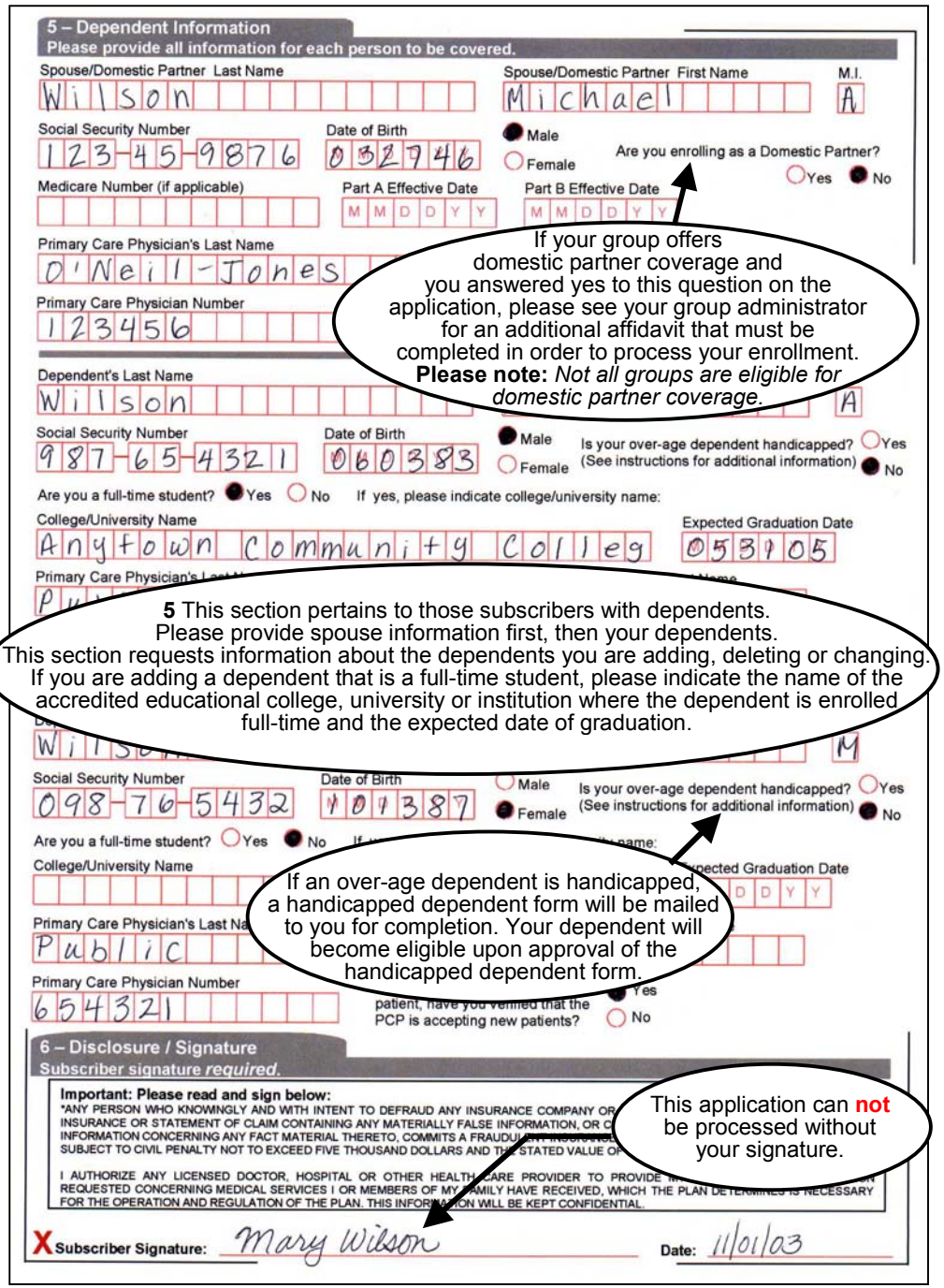
1 This section **must** be completed and signed by the **group administrator**.

Subscriber information starts here.
Please check the appropriate box for the benefit plan which is being offered.
Please be sure to indicate copay choice for HMO or HMO Plus. (Ex. $10/$20 or $15/$15)
Please refer to your enrollment packet for your specific plan copay options.

3 Fill out this section if you are a new or a current subscriber.
If you are making changes, additions or deletions, please check the boxes that apply.

4 This section requires information about **you**, the employee.
Remember, if you select an HMO or POS plan, you must indicate a **P**rimary **C**are **P**hysician Name and Number from the booklets provided or by using our online provider directory at www.bcbswny.com.

Please complete the Medicare Claim Number information if you or your spouse are 65 years of age or older or if you are disabled.



If your group offers domestic partner coverage and you answered yes to this question on the application, please see your group administrator for an additional affidavit that must be completed in order to process your enrollment.
Please note: *Not all groups are eligible for domestic partner coverage.*

5 This section pertains to those subscribers with dependents.
Please provide spouse information first, then your dependents.
This section requests information about the dependents you are adding, deleting or changing.
If you are adding a dependent that is a full-time student, please indicate the name of the accredited educational college, university or institution where the dependent is enrolled full-time and the expected date of graduation.

If an over-age dependent is handicapped, a handicapped dependent form will be mailed to you for completion. Your dependent will become eligible upon approval of the handicapped dependent form.

This application can **not** be processed without your signature.

BlueCross BlueShield of Western New York

Community Blue • Traditional Blue

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PO Box 80, Buffalo, NY 14240-0080

[redacted]

Enrollment Application/Change Form

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 # | Subgroup # | Class #

Employer Name

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

X

Subscriber Status:

◯ Active ◯ Retired ◯ COBRA

Please indicate reason for COBRA:

◯ Left Employ / Retirement ◯ Death of Spouse
◯ Divorce/Legal Separation ◯ Dependent Reached Max Age
◯ Loss of student status ◯ Other

Effective Date (M M D D Y Y)

COBRA Effective Date (M M D D Y Y)

Hire/Rehire Date (M M D D Y Y)

Retired Effective Date (M M D D Y Y)

2 – Subscriber Plan Selection

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

Traditional Blue Plan Number:

◯ POS ◯ EPO ◯ Dental
◯ PPO ◯ Traditional ◯ Vision

Community Blue Plan Number:

◯ HMO ◯ HMO Plus
◯ Other

Please indicate HMO or HMO Plus copay:

PCP $ Specialist $

Please choose coverage type Single or Family :

◯ Medical ◯ S ◯ F
◯ Dental ◯ S ◯ F
◯ Vision ◯ S ◯ F

3 – Reason for Enrollment/Change

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

◯ New Hire ◯ COBRA ◯ Primary Care Physician ◯ Remove Dependent ◯ Loss of Coverage
◯ Open Enrollment ◯ Address/Phone Number ◯ Last Name ◯ Retirement

◯ Medicare Eligible — Please indicate reason for Medicare eligibility: ◯ Age 65+ ◯ Disability ◯ End Stage Renal Disease

◯ Add Dependent — Please indicate reason for adding dependent: ◯ Newborn ◯ Marriage ◯ Loss of Coverage
◯ Adoption ◯ Domestic Partner ◯ Change in Student Status

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 | M.I.

◯ Male ◯ Female

Social Security Number | Date of Birth (M M D D Y Y) | Telephone Number (include area code)

Marital Status:
◯ Single
◯ Married
◯ Legally Separated
◯ Divorced
◯ Widowed

Mailing Address | Apt or Suite

City | State | Zip Code

Medicare Number (if applicable) | Part A Effective Date (M M D D Y Y) | Part B Effective Date (M M D D Y Y)

Marital Status Event Date (M M D D Y Y)

Primary Care Physician's Last Name | Primary Care Physician's First Name

Primary Care Physician Number (see directory)

If you are **not** a current patient, have you verified that your PCP is accepting new patients? ◯ Yes ◯ No

Do you, your spouse or any enrolled dependents have additional health coverage? ◯ Yes ◯ No

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5 – Dependent Information

Please provide all information for each person to be covered.

Spouse/Domestic Partner Last Name

Spouse/Domestic Partner First Name

M.I.

Social Security Number

Date of Birth (M M D D Y Y)

○ Male ○ Female

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

Medicare Number (if applicable)

Part A Effective Date (M M D D Y Y)

Part B Effective Date (M M D D Y Y)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ○ Yes ○ No

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Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (M M D D Y Y)

○ Male ○ Female

Is your over-age dependent handicapped? (See instructions for additional information) ○ Yes ○ No

Are you a full-time student? ○ Yes ○ No If yes, please indicate college/university name:

College/University Name

Expected Graduation Date (M M D D Y Y)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ○ Yes ○ No

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Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (M M D D Y Y)

○ Male ○ Female

Is your over-age dependent handicapped? (See instructions for additional information) ○ Yes ○ No

Are you a full-time student? ○ Yes ○ No If yes, please indicate college/university name:

College/University Name

Expected Graduation Date (M M D D Y Y)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ○ Yes ○ No

6 – Disclosure / Signature

Subscriber signature *required*.

Important: Please read and sign below:

*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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

X **Subscriber Signature:** _____ **Date:** _____

Additional Dependents
Enrollment Application/Change Form

7– Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name | Subscriber's First Name | M.I.

Social Security Number

Dependent's Last Name | Dependent's First Name | M.I.

Social Security Number | Date of Birth (M M D D Y Y) | ◯ Male ◯ Female | Is your over-age dependent handicapped? (See instructions for additional information) ◯ Yes ◯ No

Is dependent a full-time student? ◯ Yes ◯ No If yes, please indicate college/university name:

College/University Name | Expected Graduation Date (M M D D Y Y)

Primary Care Physician's Last Name | Primary Care Physician's First Name

Primary Care Physician Number | If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ◯ Yes ◯ No

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Dependent's Last Name | Dependent's First Name | M.I.

Social Security Number | Date of Birth (M M D D Y Y) | ◯ Male ◯ Female | Is your over-age dependent handicapped? (See instructions for additional information) ◯ Yes ◯ No

Is dependent a full-time student? ◯ Yes ◯ No If yes, please indicate college/university name:

College/University Name | Expected Graduation Date (M M D D Y Y)

Primary Care Physician's Last Name | Primary Care Physician's First Name

Primary Care Physician Number (see directory) | If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ◯ Yes ◯ No

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Dependent's Last Name | Dependent's First Name | M.I.

Social Security Number | Date of Birth (M M D D Y Y) | ◯ Male ◯ Female | Is your over-age dependent handicapped? (See instructions for additional information) ◯ Yes ◯ No

Is dependent a full-time student? ◯ Yes ◯ No If yes, please indicate college/university name:

College/University Name | Expected Graduation Date (M M D D Y Y)

Primary Care Physician's Last Name | Primary Care Physician's First Name

Primary Care Physician Number (see directory) | If the dependent is **not** a current patient, have you verified that the PCP is accepting new patients? ◯ Yes ◯ No

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Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

Male

Female

Is your over-age dependent handicapped? (See instructions for additional information) Yes No

Are you a full-time student? Yes No If yes, please indicate college/university name:

College/University Name

Expected Graduation Date M M D D Y Y

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

If the dependent is not a current patient, have you verified that the PCP is accepting new patients? Yes No

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth M M D D Y Y

Male

Female

Is your over-age dependent handicapped? (See instructions for additional information) Yes No

Are you a full-time student? Yes No If yes, please indicate college/university name:

College/University Name

Expected Graduation Date M M D D Y Y

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

If the dependent is not a current patient, have you verified that the PCP is accepting new patients? Yes No

HMO/POS Coverage

- If you chose HMO or POS coverage, you are entitled to direct access to care from any participating OB/GYN provider without obtaining a referral. Other medical care should be coordinated by your Primary Care Physician (PCP) whom you have chosen and listed on this application.
- Our contracts provide the following benefits:
- Coverage for hospital stay for members who have undergone a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer.
- Following a mastectomy, coverage for breast reconstruction on the affected breast and the other breast necessary to produce a "symmetrical" appearance.
- Coverage for second medical opinion following any positive or negative treatment of cancer.

Traditional Indemnity Coverage

- If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective date of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
- We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.