



Community Blue • Traditional Blue

PO Box 80, Buffalo, NY 14240-0080



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 # boxes

Employer Name box

Association/Chamber Name (if applicable) box

Group Administrator Signature / Date box

Subscriber Status:

Active, Retired, COBRA radio buttons

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

MMDDYY date box

COBRA Effective Date

MMDDYY date box

Hire/Rehire Date

MMDDYY date box

Retired Effective Date

MMDDYY date box

2 - Subscriber Plan Selection

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

Traditional Blue Plan Number, Community Blue Plan Number, POS, EPO, Dental, HMO, HMO Plus, PPO, Traditional, Vision, Other

Please indicate HMO or HMO Plus copay: PCP, Specialist, \$ boxes

Please choose coverage type Single or Family: Medical, Dental, Vision, S, F radio buttons

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, Add Dependent, etc.

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 radio buttons

Social Security Number, Date of Birth, Telephone Number, 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, Part B Effective Date, Marital Status Event Date

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?

Do you, your spouse or any enrolled dependents have additional health coverage?



Please provide all information for each person to be covered.

Spouse/Domestic Partner Last Name

[Grid for Spouse/Domestic Partner Last Name]

Spouse/Domestic Partner First Name

[Grid for Spouse/Domestic Partner First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth]

Male

Female

Are you enrolling as a Domestic Partner?

Yes  No

Medicare Number (if applicable)

[Grid for Medicare Number]

Part A Effective Date

[Grid for Part A Effective Date]

Part B Effective Date

[Grid for Part B Effective Date]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for 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

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth]

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

[Grid for College/University Name]

Expected Graduation Date

[Grid for Expected Graduation Date]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for 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

[Grid for Dependent's Last Name]

Dependent's First Name

[Grid for Dependent's First Name]

M.I.

[Grid for M.I.]

Social Security Number

[Grid for Social Security Number]

Date of Birth

[Grid for Date of Birth]

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

[Grid for College/University Name]

Expected Graduation Date

[Grid for Expected Graduation Date]

Primary Care Physician's Last Name

[Grid for Primary Care Physician's Last Name]

Primary Care Physician's First Name

[Grid for Primary Care Physician's First Name]

Primary Care Physician Number

[Grid for 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: \_\_\_\_\_

**New Employer Group Enrollment Form for  
Chambers/Associations and Payroll Administrators  
Sole Proprietor**

Chamber/Association/Payroll Administrator Name: \_\_\_\_\_

Employer Group Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Employer Federal ID No.: \_\_\_\_\_ Member of Chamber/Association since: \_\_\_/\_\_\_/\_\_\_

**The following requirements apply to Sole Proprietors.** A sole proprietor group is defined as an unincorporated business, partnership or corporation whose owner, partner, stockholder, as applicable is the only active employee. To be eligible for enrollment as a sole proprietor, the following requirements must be met. The applicant must:

1. be a member of a Chamber/Association, Group or Payroll Administrator that meets BlueCross BlueShield eligibility criteria and the requirements of the Insurance Law;
2. if purchasing through a chamber/association group, the subscriber must have been a member for a period of sixty days prior to the effective date of the insurance policy;
3. demonstrate that the applicant is a bona fide sole proprietor through the documentation requirements set forth in the table below;
4. work at least twenty hours per week;
5. not be employed by another business that has additional employees or be enrolled in any type of health care coverage under another employer group.

**For all new groups, the appropriate documentation must be attached to this submission. All paperwork, including applications must be received by the 15<sup>th</sup> of the month prior to the effective date.**

Type of Group	Required Documentation
<b>Sole Proprietor</b>	1) Copy of NYS-45-ATT-MN <b>OR</b> copy of pay stub <b>OR</b> estimated tax form 2) Schedule C
<b>Subchapter S Corporation w/Sole Employee</b>	1) Copy of NYS-45-ATT-MN <b>OR</b> copy of pay stub <b>OR</b> estimated tax form 2) Schedule E
<b>Other Incorporated Business w/Sole Employee</b>	1) Copy of NYS-45-ATT-MN <b>OR</b> copy of pay stub <b>OR</b> estimated tax form 2) Form W-2 Annual Wage Statement <b>OR</b> Form 1099 with Federal Income Tax Schedule F
<b>Business in Business Less Than One Year</b>	1) Copy of cancelled Business Check <b>OR</b> copy of a business Bank Statement <b>OR</b> a Certificate of doing business <b>OR</b> Appropriate Tax Documents

**By signing below the employer group or sole proprietor certifies that they meet the eligibility requirements to be enrolled.** I certify that the above information is true and accurate to the best of my knowledge. I understand that enrollment is subject to BlueCross BlueShield of Western New York underwriting guidelines and the Group Health Care contract between the Chamber/Association and BlueCross BlueShield. I understand that BlueCross BlueShield will conduct annual audits to ensure compliance with enrollment guidelines, which may require us to provide verification of our being a legitimate employer and/or sole proprietor.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date

**New Employer Group Enrollment Form for  
Chambers/Associations and Payroll Administrators  
Small Group (2-50 eligible employees)**

Chamber/Association/Payroll Administrator Name: \_\_\_\_\_

Employer Group Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Employer Federal ID No.: \_\_\_\_\_ Member of Chamber/Association since: \_\_\_/\_\_\_/\_\_\_

The purpose of this documentation is to assure the group has a legitimate existence, and was not formed solely for the purpose of seeking insurance. The group must produce documentation of actual existence (checking account, certificate of incorporation or NYS-45-ATT for unemployment insurance) and that it is active and doing business. If a NYS-45-ATT is not available due to a group being newly formed, then the NYS-45-ATT must be provided within 90 days of the effective date of coverage. If such documentation is not provided, the group will be terminated on the 90<sup>th</sup> day. **All paperwork, including applications, must be received by the 15<sup>th</sup> of the month prior to the effective date.**

**If the group does not file a NYS-45-ATT due to other reasons, they must provide the documentation listed in the table below. In addition, two months of premium must be submitted on a company check with the enrollment paperwork and subscriber applications for approval prior to enrollment:**

Type of Group	Required Documentation
<b>Partnership</b>	1) Form IT-204 <b>OR</b> IT-204 ATT <b>OR</b> IT-204-LL 2) Schedule 1065, <b>PLUS</b> one of the following: <ul style="list-style-type: none"> <li>• Copy of Federal ID</li> <li>• Partnership Agreement</li> </ul>
<b>Corporation/Subchapter S Corporation</b>	1) Schedule 1120C, 1120E Sub-S Schedule 1120S, <b>Plus</b> one of the following: <ul style="list-style-type: none"> <li>• Copy of Federal ID</li> <li>• Articles of Incorporation</li> <li>• Copy of Federal 941 Report</li> <li>• Initial Form SS4</li> </ul> 2) The W-4 for each additional employee 3) Pay stubs or payroll records for all employees
<b>Business in Business Less Than One Year</b>	1) Copy of cancelled Business Check <b>OR</b> copy of a business Bank Statement <b>OR</b> a Certificate of doing business <b>OR</b> Appropriate Tax Documents, <b>Plus</b> one of the following: <ul style="list-style-type: none"> <li>• Copy of Federal ID</li> <li>• Articles of Incorporation</li> <li>• Copy of Federal 941 Report</li> <li>• Initial Form SS4</li> </ul> 2) Pay stubs or payroll records for all employees

**By signing below the employer group certifies that they meet the eligibility requirements to be enrolled. I certify that the above information is true and accurate to the best of my knowledge. I understand that enrollment is subject to BlueCross BlueShield of Western New York underwriting guidelines and the Group Health Care contract between the Chamber/Association and BlueCross BlueShield. I understand that BlueCross BlueShield will conduct annual audits to ensure compliance with these guidelines, which may require us to provide verification of our being a legitimate employer group.**

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date