BlueShield of Northeastern New York

[redacted]

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 # 00961391

Subgroup #

Class # 0001

Employer Name: SKIDMORE COLLEGE

Association/Chamber Name (if applicable)

Group Administrator Signature / Date

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 (MMDDYY)

COBRA Effective Date (MMDDYY)

Hire/Rehire Date (MMDDYY)

Retired Effective Date (MMDDYY)

2—Subscriber Plan Section

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

Plan Number: 0898 Please indicate copay: PCP $ Specialist $

○ POS ○ POS Plus ○ Dental ○ HMO ○ HMO Plus
● PPO ○ Traditional ○ Vision ○ EPO ○ Aqua ○ Other

Please choose coverage type ● Medical ○ S ○ F

Single or Family: ○

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
○ 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.

Social Security Number

Date of Birth (MMDDYY)

Telephone Number (include area code)

Gender: ○ Female ○ Male

Mailing Address

○ Apt ○ Suite

Marital Status ○ Single ○ Married ○ Divorced ○ Legally Separated ○ Widowed

City

State

Zip Code

E-mail Address

Marital Status Event Date (MMDDYY)

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

Medicare Number (if applicable)

Part A Effective Date (MMDDYY)

Part B Effective Date (MMDDYY)

Part D Effective Date (MMDDYY)

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4—Subscriber Information continued

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer

Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

5—Dependent Information Please provide all information for each person to be covered.

Spouse/Domestic Partner's Last Name | Spouse/Domestic Partner's First Name | M.I.

Social Security Number | Date of Birth (MMDDYY) | ○ Male ○ Female

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

E-mail Address

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

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

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer

Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

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

Social Security Number | Date of Birth (MMDDYY) | ○ Male ○ Female

Is your over-age dependent handicapped? ○ Yes ○ No

E-mail Address

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

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

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

College/University Name | Expected Graduation Date (MMDDYY)

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer

Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

Additional Dependents
Enrollment Application/Change Form

5—Dependent Information continued

Please provide all information for each person to be covered.

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

Social Security Number | Date of Birth (MMDDYY)

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

Social Security Number | Date of Birth (MMDDYY) | ○ Male ○ Female | Is your over-age dependent handicapped? ○ Yes ○ No

E-mail Address

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

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

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

College/University Name | Expected Graduation Date (MMDDYY)

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer

Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

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

Social Security Number | Date of Birth (MMDDYY) | ○ Male ○ Female | Is your over-age dependent handicapped? ○ Yes ○ No

E-mail Address

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

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

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

College/University Name | Expected Graduation Date (MMDDYY)

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer

Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

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5—Dependent Information continued

Please provide all information for each person to be covered.

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

Social Security Number | Date of Birth (MMDDYY) | ○ Male ○ Female | Is your over-age dependent handicapped? ○ Yes ○ No

E-mail Address

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

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

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

College/University Name | Expected Graduation Date (MMDDYY)

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

Primary Care Physician Number

Are you a current patient, or if not a current patient, have you verified that the PCP will accept you as a new patient? ○ Yes ○ No

Name of Prior Health Care Insurer | Do you have additional group health insurance? ○ Yes ○ No

Policy Identification Number | Policy Effective Date (MMDDYY) | Policy Cancellation Date (MMDDYY)

HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and;
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Traditional 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.

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.

✓ **Subscriber Signature** _____ **Date** _____