



P.O. Box 22999, Rochester, NY 14692

A nonprofit independent licensee of the BlueCross BlueShield Association

GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

Instructions on Back. All Dates = mm/dd/yy [] Check if name change [] Check if new address Please print clearly.

Form section for checking desired actions (Add Subscriber, Add Dependent, Change Coverage) and medical/dental/vision coverage options.

Form section for subscriber information, including Social Security number, birthdate, last name, first name, street, city, state, zip, and medical center selection.

Form section for family member information, including checkboxes for spouse, dependent, student, disabled, partner, etc., and fields for social security, sex, birthdate, and medical center.

Form section for other coverage information, including a request for a certificate of coverage and checkboxes for previous insurance companies.

RELEASE - You must sign and date this form to be eligible for insurance. 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. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature _____ Date _____

EMPLOYER INFORMATION (Must be completed by Group Administrator) *Deductible Amt., Dept. # and Employee # is optional.

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

If yes, what was the start date / / and end date / /

Table with columns: Coverage, Group/Sub Group #, Chk digit, Pkg #, Deductible Amount*, Employer Name, Employee Status, Department #*, Employee #*, Group Rep Signature/Date.