



PO Box 80, Buffalo, NY 14240-0080

## **Enrollment Application/Change Form — SMALL**

Subscriber Status:   Active   Retired   COBRA   Please indicate reason for COBRA:	
Group # Subgroup # Class # Left Employ / Retirement Death of Spouse	
0 0 3 1 0 7 5 0 Divorce/Legal Separation Dependent Reached M	ax Age
Employer Name	
Effective Date (MMDDYY) COBRA Effective Date (MMI	DYY)
Association/Chamber Name (if applicable)	
Grand Island Chamber of Commerce  Hire/Rehire Date (MMDDYY)  Retired Effective Date (MMDDYY)	Y)
Group Administrator Signature / Date	
<b>√</b>	
Subscriber Plan Section Please use blue or black ink, print one character per box. Check applicable plan(s).	
Plan Number: Please indicate copay: PCP \$ Specialist \$ Single 0	r Family
O POS O POS Plus O Dental O HMO O HMO Plus Please choose coverage type O Medical O S	O F
OPPO Traditional Vision EPO Aqua Other Dental S	O F
○ Vision ○ S	O F
A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? Yes No B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.	1
If you answered "no", we will provide coverage of the pediatric dental essential health benefit.	
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	
4—Subscriber Information Adoption Domestic Partner Change in Studen	
4—Subscriber Information Adoption Domestic Partner Change in Studen Please complete both sides of this application. The subscriber signature is required in order to process the application.	
	Status
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Please complete both sides of this application. The subscriber signature is required in order to process the application.	Status
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:	Status
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:	Status
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:  Mailing Address  Apt  Suite  Marital Status  Signature is required in order to process the application.  M.I  Subscriber's First Name  M.I  Subscriber's First Name  M.I  Subscriber's First Name  M.I  Suite  Marital Status  Signature is required in order to process the application.	Status Female Male
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:  Mailing Address  Apt  Suite  Marital Status  Signature is required in order to process the application.  M.I  Subscriber's First Name  M.I  Subscriber's First Name  M.I  Subscriber's First Name  M.I  Suite  Marital Status  Signature is required in order to process the application.	Status Female Male agle orced
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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:  Mailing Address  Apt  Suite  Married  Div  City  State  Zip Code  Legally Separate	Status Female Male igle orced
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:  Mailing Address  Apt  Suite  Marital Status  Sin  City  State  Zip Code  Legally Separate  Widowed	Status Female Male igle orced
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A division of HealthNow New York Inc., an independent licensee of the BlueCross BlueShield Association.

Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified Do you Name of Prior Health Care Insurer  Policy Identification Number Policy Information Please provide all information for each person Spouse/Domestic Partner's Last Name Spouse/Domestic Partner's Last Name Spouse/Domestic Partner's Last Name Social Security Number Date of Birth (MMDDYY) Gomestic Partner's Last Name Primary Care Eligible Please indicate reason for Medicare eligibility: Age 65+  Medicare Number (if applicable) Part A Effective Date (MMDDYY) Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified Do you Name of Prior Health Care Insurer  Policy Identification Number Policy Identification Number Policy Insurer Policy Identification Number Policy Identification Identif	Effective Date (MMDD)  To be covered.  Se/Domestic Partne  Sender: Ferre you enrolling as a server of the property of the prop	ept you as a up health  YYY)  r's First N  male a Domesti  End  MDDYY)  ian's First	a new patie  Policy Ca  Name  Mal  ic Partner  Stage Re  Part D Ef	e e enal Disease fective Da	Yes	M.I.	No No No No
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Primary Care Physician's Last Name Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified Do you Name of Prior Health Care Insurer Policy Identification Number Policy Identification Number Dependent's Last Name Depen	rimary Care Physic	ian's First	t Name a new patie	ent?	Yes	0	
Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verified  Do you  Name of Prior Health Care Insurer  Policy Identification Number  Policy Identification Number  Dependent's Last Name  Deper	d that the PCP will acce	ept you as a	a new patie			0	
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Do you  Ilame of Prior Health Care Insurer  Policy Identification Number Policy Identification Number Dependent's Last Name Depen		-				0	
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	ender:	male	O Mal	е	,		1
	your dependent di	sabled?		$\bigcirc$	Yes	$\bigcirc$	No
E-mail Address							
Medicare Eligible Please indicate reason for Medicare eligibility:  Age 65+	Disability	End	l Stage Re	enal Disea	ase		
Medicare Number (if applicable) Part A Effective Date (MMDDYY) P.	art B Effective Date (M		•			DYY)	
s dependent a full-time student? Yes No If yes, please in	ndicate college/univ	versity na	me:				
College/University Name	5	-	ected Grad	duation Da	ate (MMI	DDYY)	
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Primary Care Physician's Last Name	rimary Care Physic	ian's First	t Name				
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Primary Care Physician Number: Are you a current patient, or if not a current patient, have you verifier	d that the PCP will acce	ept vou as a	a new natie	ent?	J Yes	$\bigcirc$	No
	have additional gro	-			Yes	$\bigcirc$	No
f you answered "yes" to the question about stand-alone dental coverage in section 2, plea	_						140

5—Dependent Information continued		
Please provide all information for each pe	erson 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) Gender: Female Male	
	Is your dependent disabled? Yes	O No
E-mail Address		
2 mail / todioo		
Medicare Eligible Please indicate reason for Me	edicare 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 (MMDD	DYY)
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Is dependent a full-time student? Yes	No If yes, please indicate college/university name:	
College/University Name	Expected Graduation Date (MMD	וראאן
Conlegerative sity (Value	Expected Graduation Pate (vivid	D11)
Primary Care Physician's Last Name	Primary Care Physician's First Name	
Timary cure i hydrolan a East Name	Timaly Suite Hysioland File Name	
Primary Care Physician Number: Are you a current patient	t, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes	O No
		<u> </u>
	Do you have additional droup health insurance? The Yes	( ) No
If you answered "yes" to the question about standals	Do you have additional group health insurance? Yes	O No
If you answered "yes" to the question about stand-ald	one dental coverage in section 2, please provide the name of the company issuing the coverage	
	one dental coverage in section 2, please provide the name of the company issuing the coverage	
If you answered "no", we will provide coverage of	one dental coverage in section 2, please provide the name of the company issuing the coverage the pediatric dental essential health benefit.	e.
	one dental coverage in section 2, please provide the name of the company issuing the coverage	
If you answered "no", we will provide coverage of Dependent's Last Name	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name	e.
If you answered "no", we will provide coverage of	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY)  Gender: Female Male	e. M.I.
If you answered "no", we will provide coverage of  Dependent's Last Name  Social Security Number	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name	e.
If you answered "no", we will provide coverage of Dependent's Last Name	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY)  Gender: Female Male	e. M.I.
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If you answered "no", we will provide coverage of  Dependent's Last Name  Social Security Number  E-mail Address	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY)  Gender: Female Male  Is your dependent disabled? Yes	M.I. No
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If you answered "no", we will provide coverage of  Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student?  Yes	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY) Gender: Female Male  Is your dependent disabled? Yes  edicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  No If yes, please indicate college/university name:	M.I.  No
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If you answered "no", we will provide coverage of  Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student?  Yes	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY) Gender: Female Male  Is your dependent disabled? Yes  edicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  No If yes, please indicate college/university name:	M.I.  No
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If you answered "no", we will provide coverage of Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student?  Yes  College/University Name  Primary Care Physician's Last Name	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY) Gender: Female Male  Is your dependent disabled? Yes  edicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  No If yes, please indicate college/university name:  Expected Graduation Date (MMDD	M.I.  No
If you answered "no", we will provide coverage of Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student?  Yes  College/University Name  Primary Care Physician's Last Name	one dental coverage in section 2, please provide the name of the company issuing the coverage if the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY) Gender: Female Male  Is your dependent disabled? Yes  edicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  No If yes, please indicate college/university name:  Expected Graduation Date (MMDDY)  Primary Care Physician's First Name	e.  M.I.  No  No
If you answered "no", we will provide coverage of Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student?  Yes College/University Name  Primary Care Physician's Last Name  Primary Care Physician Number: Are you a current patient	one dental coverage in section 2, please provide the name of the company issuing the coverage in the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY) Gender: Female Male  Is your dependent disabled? Yes  edicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  No If yes, please indicate college/university name:  Expected Graduation Date (MMDDY)  Primary Care Physician's First Name  t, or if not a current patient, have you verified that the PCP will accept you as a new patient? Yes	e.  M.I.  No  No  DYY)  No  No  No
If you answered "no", we will provide coverage of Dependent's Last Name  Social Security Number  E-mail Address  Medicare Eligible Please indicate reason for Medicare Number (if applicable)  Is dependent a full-time student? Yes  College/University Name  Primary Care Physician's Last Name  Primary Care Physician Number: Are you a current patient	one dental coverage in section 2, please provide the name of the company issuing the coverage in the pediatric dental essential health benefit.  Dependent's First Name  Date of Birth (MMDDYY)	e.  M.I.  No  No  DYY)  No  No  No



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u answered "ves" to the question about stand-alor	ne dental coverage in section 2, ple	ase provide the name of	it the company issuinc	i the covera	
O/POS Coverage  O/POS Coverage  Du have had or are going to have a mastectomy HCRA). For individuals receiving mastectomy-re	he pediatric dental essential hea	Ith benefit.	nen's Health and Cal	ncer Rights	Act o
rou answered "no", we will provide coverage of the MO/POS Coverage on the had or are going to have a mastectomy (HCRA). For individuals receiving mastectomy-respectation and the patient, for:  All stages of reconstruction of the breast on we Surgery and reconstruction of the other breast Prostheses; and;  Treatment of physical complications of the mastese benefits will be provided subject to the same	he pediatric dental essential hear, you may be entitled to certain belated benefits, coverage will be which the mastectomy was perfort to produce a symmetrical appears	oth benefit.  Denefits under the Word or ovided in a manner of med;  arance;	nen's Health and Cal letermined in consult	ncer Rights tation with t	Act o
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