Non-Group Conversion Application

Excellus

344 S. Warren St., Syracuse, New York 13221

DO NOT USE - MICROFILM ONLY

All Dates = mm/dd/yy ❑ Check if name change ❑ Check if new address

Please print clearly using Blue Ink.

✓ CHECK DESIRED COVERAGE

Blue Cross ❑ Individual
Blue Cross ❑ Family
Blue Shield ❑ Individual
Blue Shield ❑ Family
Major Medical $ 500 Deductible ❑ Yes ❑ No

I wish to be billed
❑ Monthly ❑ Quarterly
❑ Annually

Enrolled with Medicare ❑ Y ❑ N
If yes, indicate reason
- ❑ Age
- ❑ Disabled
- ❑ ESRD

Medicare Claim No________________
Medicare Part A Eff Date____/_____/_____
Medicare Part B Eff Date____/_____/_____

Subscriber information - Must be completed – Incorrect or missing information may cause delays in claim payments. (Please print in ink)

Social Security #|_|_|_|-|_|_|-|_|_|_|_|

Sex: ❑ M ❑ F Birthdate ___ / ___ / ___

Last Name______________________________ First__________________________

Street____

City____________________________________State______________________

Zip__________________County____________________________

Day Phone: |_|_|_|-|_|_|_|-|_|_|_|_| e-mail ______________________________

FAMILY MEMBER INFORMATION

Member	Medicare	Sex	Birthdate (mm/dd/yy)
❑ (S)pouse ❑ (D)ependent ❑ (H) Disabled Dependent ❑ Other ________________ Social Security #________________ **Last Name (if different)** **First Name**	Is dependent disabled? ❑ Y ❑ N Enrolled with Medicare? ❑ Y ❑ N If yes, indicate reason ❑ Age ❑ Disabled ❑ ESRD Medicare Claim # Medicare Part A eff date Medicare Part B eff date ____________ ___/___/___ __/___/__	❑ M ❑ F	___/___/__
❑ (S)pouse ❑ (D)ependent ❑ (H) Disabled Dependent ❑ Other ________________ Social Security #________________ **Last Name (if different)** **First Name**	Is dependent disabled? ❑ Y ❑ N Enrolled with Medicare? ❑ Y ❑ N If yes, indicate reason ❑ Age ❑ Disabled ❑ ESRD Medicare Claim # Medicare Part A eff date Medicare Part B eff date ____________ ___/___/___ __/___/__	❑ M ❑ F	___/___/__
❑ (S)pouse ❑ (D)ependent ❑ (H) Disabled Dependent ❑ Other ________________ Social Security #________________ **Last Name (if different)** **First Name**	Is dependent disabled? ❑ Y ❑ N Enrolled with Medicare? ❑ Y ❑ N If yes, indicate reason ❑ Age ❑ Disabled ❑ ESRD Medicare Claim # Medicare Part A eff date Medicare Part B eff date ____________ ___/___/___ __/___/__	❑ M ❑ F	___/___/__

OTHER COVERAGE INFORMATION - Must be completed.
Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)? ❑ Yes ❑ No ✓ Check: ❑ Medical and/or ❑ Dental Are you keeping this coverage? ❑ Yes ❑ No If No, indicate cancel date ___ / ___ / ___
Policyholder's Name________________________Effective Date: ___ / ___ / ___ Did this insurance cover ❑Insured ❑ Insured and Family
✓ Check previous insurance company from list below and indicate ID #:__________________
❑ (B) Excellus BlueCross BlueShield
❑ (O) Other - Blue Cross Blue Shield Plan. Indicate Plan Name:______________________________
❑ (C) Other Carrier - Indicate Plan Name:____

EMPLOYMENT INFORMATION

Name and address of present employer ____
Employment date: ___ / ___ / ___ No. of employees _______ Does your employer offer group health insurance? ❑ Yes ❑ No
Spouse's Social Security No.____________________
Name and address of spouse's employer ________________________ No. of employees________
Does spouse's employer offer group health insurance? ❑ Yes ❑ No Spouse's employement ❑ Full time ❑ Part time

RELEASE - You must sign and date this form to be eligible for insurance.
The contract for which application is being made limits coverage for pre-existing conditions, and contains probationary period of up to 330 days. It provides maternity benefits for pregnancy beginning after the effective date of coverage.
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.
Subscribers Signature______________________________________ **Date**________________

Instructions for completing the Direct Enrollment Application

Medicare

If you are Medicare eligible and enrolled in Medicare Part A and Medicare B, do not complete this application.
Please contact Customer Service for the Direct/Supplemental Medicare Eligible Enrollment Form or Direct/HMO Medicare Eligible Enrollment Form

Desired Action

Check the appropriate action and indicate the date(s) in the space provided. An Event Date is the date of a specific occurrence, due to marriage, divorce, birth or adoption. Your request **must** be received within 30 days of the Event Date. If New Add Subscriber, Add Dependent or Change Coverage, you **must** also check Desired Coverage and Persons Covered and Family Member(s) and Doctor Information sections.

Subscriber Information

Indicate Bill Cycle
Answer all questions
Subscriber – all information must be completed

Other Coverage Information

Please be sure to include accurate information. This could affect the processing of your application and/or claims.
Medicaid is a public aid program for those with a limited income. This is not the same as Medicare.

Family Member Information – **Use an additional form if more than three persons.**

Qualified Guidelines:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Unmarried eligible dependents who are chiefly dependent on you for support (Must be under age 19, unless certified by us as incapable of self-sustaining employment.)
  - Biological children
  - Children for whom you are legal guardian
  - Children who have been place with you for adoption
  - Children of your spouse
  - Your adopted children

Release

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I understand that any claim by me or one of my eligible family members may be denied and my coverage cancelled upon one month's written notice, if I have knowingly include false information.

I understand that this contract is subject to a 330 day waiting period for pre-existing conditions that have existed for a six (6) month period prior to my applying for this benefit, unless prior coverage affords credits for some or all of this time period.

Any pre-existing condition-waiting period established under the contract will not apply to an eligible individual. Federal regulations define an "eligible individual" as one:

- who has had at least 18 months of prior creditable coverage without a significant break (63 or more consecutive days without coverage);
- whose most recent coverage under an employment related group health plan and was not terminated because of fraud of nonpayment of premiums;
- who is not currently eligible for Medicare, Medicaid or a group health plan and is not covered under any other health insurance;
- who has elected and exhausted any available COBRA or State-established continuation coverage.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Child Health Plusמעמבער אדער Managed Medicaid, ביטע רופט 1-800-650-4359. מעמבער, ביטע רופט 1-877-626-9298. אלע אנדערע ביטע רופט Essential Plan אויב איר זענט אן 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضوًا في Child Health Plus أو Managed Medicaid ، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضوًا في Essential Plan ، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid اگر آپ 1-800-650-4359 پر کال کریں۔ ممبر ہیں تو براہ کرم Essential Plan1- کے ممبر ہیں تو براہ کریم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.