Excellus

P.O. Box 21146, Eagan, MN 55121-0146
A nonprofit independent licensee of the BlueCross BlueShield Association

FLASHP
GROUP ENROLLMENT FORM

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#_____
EC_____

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

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 # 00044299 Subgroup # _____ Class# _____

Employer Name: Geneseo CSD

Association/Chamber Name (if applicable):

Group Administrator Signature/Date: X

Dental Group # _____ Subgroup # _____

Subscriber Status:

____ Active ____ Retired _____ COBRA _____ Cancelled

Please indicate reason for COBRA:

___ Left Employ/Retirement ___ Death of Spouse
___ Divorce/Legal Separation ___ Dependent Reached Max Age
___ Other _____

Effective Date _____ COBRA Effective Date _____

Hire/Rehire Date _____ Retired Effective Date _____

Subscriber Name: _____

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

If yes, what was the start date: _____ and end date _____

2 – Subscriber Plan Selection

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

	Blue Point 2 $15/$15 ☐ $5/$15/$30 RX (EF)	**Blue Point 2 $20/$20** ☐ $10/$25/$40 RX (ET)	Blue Point 2 Medical: ☐ single ☐ 2 person ☐ family no spouse ☐ family
Healthy Blue Copay ☐ $25 PCP/$40 Specialist (A2)	**Signature HDHP** $1,500S/$3,000F w/20% Coinsurance ☐ BKW		Healthy Blue/Signature Medical: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family
			Dental (DJ) ☐ Dental Blue Option 3 Dental: ☐ single ☐ EE/Spouse ☐ EE/Child(ren) ☐ family

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

___ New Hire ____ COBRA ____ Retirement ____ Loss of Coverage ____ Domestic Partner

____ Open Enrollment ____ Address/Phone Number ____ Last Name ____ Age 65+ ____ Remove Dependent

___ Medicare Eligible / Please indicate reason for Medicare eligibility: ___ Newborn ___ Disability ___ End Stage Renal Disease

____ Add Dependent / Please indicate reason for adding dependent: ___ Adoption ___ Marriage ___ Marital Status Change

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 _____

Middle Initial ____ Title _____ E-mail Address _____

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

Ob/Gyn's Last Name _____ Ob/Gyn's First Name _____

Are you a Previous Patient of PCP? ____ Yes ____ No

Are you a Previous Patient of Ob/Gyn? ____ Yes ____ No

Mailing Address _____ Apt or Suite _____

City _____ State ____ Zip _____

Work Phone Number _____ Home Phone Number _____ Cell Phone Number _____

Date of Birth ____-____-____ Gender ____ M ____ F Social Security Number* ____-____-____

Marital Status: ____ Single ____ Married ____ Legally Separated ____ Divorced/ Marital Status Event Date _____

Medicare Number (if applicable) _____ Part A Effective Date _____ Part B Effective Date _____

If Medicare eligible due to ESRD please check type of dialysis: ____ Self administered ____ Facilitated Date started _____

5 – Other Coverage Information

Have you ever been a member of Excellus BlueCross BlueShield? ___ Yes ___ No

In addition, please provide a copy of your "Certificate of Coverage" from your former dental insurance carrier or employer.

Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)?

Health?___No ____Yes / Dental? ____ No ____ Yes

If answering "Yes", are you keeping the additional health or dental coverage? Health? ___ No ___ Yes / Dental? ___ No ____ Yes

Who did the other plan cover? ____ Self ____ Spouse ____ Children

Other insurance carrier name: _____

Other insurance name of policyholder: _____

Policy ID Number: _____ Effective Date _____ Termination Date _____

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ____ Medical /Reason _____ Date _____

____ Dental /Reason _____ Date _____

Dependent (list each dependent in section 7)

___ Medical / Reason _____ Date _____

___ Dental / Reason _____ Date _____