



# University of Rochester Student Dental

P.O. Box 22999, Rochester, NY 14692-2999

A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on Back. All Dates = mm/dd/yy  Check if name change  Check if new address

Please print clearly.

| ✓ CHECK DESIRED ACTION   | ✓ CHECK DESIRED COVERAGE                        | ✓ CHECK PERSON(S) COVERED     |                          |                          |                          |
|--|---|-------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Add Subscriber (AA) Fall Quarter<br>College Enrollment Date 9/01/06<br>Coverage Effective Date 9/01/06  | <input checked="" type="checkbox"/> Dental (DE) | Self, Spouse & Child(ren) (A) | Self & Child(ren) (B)    | Self & Spouse (C)        | Self (D)                 |
| <input type="checkbox"/> Add Dependent (AB)<br>Event Date __/__/__<br>Coverage Effective Date __/__/__   |   | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Change Coverage (AC)<br>Coverage Effective Date __/__/__  |   |                               |                          |                          |                          |
| <input type="checkbox"/> Cancel Subscriber (S)<br><input type="checkbox"/> Cancel Dependent (M)<br><input type="checkbox"/> (D)ental<br>Reason Code (see back) _____<br>Cancellation Date __/__/__ |   |                               |                          |                          |                          |

### SUBSCRIBER INFORMATION - Must be completed

Social Security # \_\_\_\_\_ Sex:  M  F Birthdate \_\_/\_\_/\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] E-Mail Address: \_\_\_\_\_

### MEDICARE HEALTH INSURANCE CLAIM # \_\_\_\_\_

### FAMILY MEMBER INFORMATION ✓ Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

|  |                         |   |                                  |
|--|-------------------------|---|----------------------------------|
| <input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled<br><input type="checkbox"/> Other _____<br>Last Name (if different) _____ First Name _____ | Social Security # _____ | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Birthdate (mm/dd/yy)<br>__/__/__ |
| <input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled<br><input type="checkbox"/> Other _____<br>Last Name (if different) _____ First Name _____ | Social Security # _____ | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Birthdate (mm/dd/yy)<br>__/__/__ |
| <input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled<br><input type="checkbox"/> Other _____<br>Last Name (if different) _____ First Name _____ | Social Security # _____ | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Birthdate (mm/dd/yy)<br>__/__/__ |

### OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.

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

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

✓ Check previous insurance company from list below and indicate ID #: \_\_\_\_\_

(B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice.

(O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name: \_\_\_\_\_

(C) Other Carrier - Indicate Plan Name: \_\_\_\_\_

### 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 \_\_\_\_\_

| Coverage | Group/Sub Group # | Chk digit | Pkg # | Employee Status <input checked="" type="checkbox"/> (A) Active   |
|----------|-------------------|-----------|-------|--|
| Dental   | 13997-501         |           |       | Name of School: _____<br>Address: _____<br>School Phone #: _____ |

Group Rep Signature/Date \_\_\_\_\_

## Instructions for completing the 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 change in status, marriage, divorce, birth or adoption, anniversary date, or rate change. Your request **must** be received within 30 days of the Event Date. Please see your Group Representative for events that fall outside the 30 day period. If New Add Subscriber, Add Dependent or Change Coverage, you must also check Desired Coverage and Persons Covered and Family Member information sections

### Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet – OR -**

#### To Cancel an Employee/Subscriber using this Form:

- check Subscriber (S) box
- check Products to be cancelled (Dental)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### To Cancel a Dependent using this Form:

- check Dependent (M) box
- check Products to be cancelled (Dental)
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- Complete Member Name and Member Birthdate

#### Cancel Subscriber Reasons

LE – Left Employer/No Longer Eligible      CE – Cobra End Date  
PC - Preferred Care                              SR – Subscriber Request  
CP- Commercial                                  SD – Subscriber Deceased  
CB – Cobra Begin Date                          SB – Spouse's BCBS  
CD – Cobra Disabled Date                      MC - Medicaid

#### Cancel Dependent Reasons

MA – Marriage                                      MB – Cobra Begin Date  
OA – Dependent Over Age                      MR- Subscriber Request  
DM – Deceased                                    DV - Divorce

If the only change is one of the following, please call Customer Service at the number listed below. A Group Enrollment Form is not required.

- Address                    ➤ Birthdate                    ➤ PCP                    ➤ OB/GYN                    ➤ Medical Center

### FAMILY MEMBER AND DOCTOR 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)
- Must be under the dependent age for your group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
  - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.**  
Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your group.

### 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 accept 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 canceled upon one month's written notice, if I have knowingly included false information.

**If you have any questions, please contact Customer Service at:  
Excellus BlueCross BlueShield, (585) 325-3630 or 1-800-847-1200**