Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

P.O. Box 21146 Eagan, MN 55121-0146

University of Rochester
Student Dental

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			
❑ Add Subscriber (AA) Fall Semester College Enrollment Date Coverage Effective Date	✓ **Dental (DE)**	Self, Spouse & Child(ren) (A) ☐	Self & Child(ren) (B) ☐	Self & Spouse (C) ☐	Self (D) ☐
❑ Add Subscriber (AA) Spring Semester College Enrollment Date Coverage Effective Date					
❑ Add Subscriber (AA Special Enrollment Period (SEP) Special Enrollment Period____.____.____ Coverage Effective Date ____.____.____					
❑ Add Dependent (AB) Special Enrollment Period (SEP) Special Enrollment Period____.____.____ Coverage Effective Date ____.____.____	❑ Cancel Subscriber (S) ❑ Cancel Dependent (M) Reason Code (see back) _____ Cancellation Date ____.____.____				

SUBSCRIBER INFORMATION - Must be completed

Social Security # Gender: ❑ M ❑ F Birthdate _______ _______ _______

Last Name_________________________________ First_________________________________

Street____

City_________________________________ State_______________ Zip_______________

Day Phone: |__.__.__| |__.__.__| |__.__.__.__| E-Mail Address:_________________________

Gender identity (optional):
☐Transgender Male
☐Transgender Female
☐Prefer not to say
☐Non-binary
☐Prefer to self-describe: _______

MEDICARE HEALTH INSURANCE CLAIM # _________________________ Part A Effective Date: ___ ___ ___ Part B Effective Date: ___ ___ ___

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

Relationship / Name	Social Security #	Gender	Birthdate (mm/dd/yy)	Gender identity (optional)
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other____________________ *Last Name (if different)* *First Name*	Social Security #	Gender ❑ M ❑ F	Birthdate (mm/dd/yy) ____.____.____	Gender identity (optional): ☐Transgender Male ☐Non-binary ☐Transgender Female ☐Prefer to self-describe: _______ ☐Prefer not to say
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other____________________ *Last Name (if different)* *First Name*	Social Security #	Gender ❑ M ❑ F	Birthdate (mm/dd/yy) ____.____.____	Gender identity (optional): ☐Transgender Male ☐Non-binary ☐Transgender Female ☐Prefer to self-describe: _______ ☐Prefer not to say
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other____________________ *Last Name (if different)* *First Name*	Social Security #	Gender ❑ M ❑ F	Birthdate (mm/dd/yy) ____.____.____	Gender identity (optional): ☐Transgender Male ☐Non-binary ☐Transgender Female ☐Prefer to self-describe: _______ ☐Prefer not to say

OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.
Have you or any member of your family been enrolled in any other insurance policy (including Dental, Medicare or Medicaid)?

❑ Yes ❑ No If yes, ✓ Check: ❑ Medical and/or ❑ Dental

What is the effective date of the other coverage? ☐Medical: ____.____.______ ☐Dental: ____.____.______

What is the name of the other carrier(s)? ____

Are you keeping the coverage? ☐Yes ☐No If no, when will the coverage end? ☐Medical: ____ ____ ______ ☐Dental: ____ ____ ______

Policyholder's name ______________________________ ID#(s) ____________________

Who did the insurance cover? ◯Self Only ◯Self & Spouse/Domestic Partner ◯Self & Child(ren) ◯Family

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.

Subscriber Signature____**Date**____________________

Coverage	Group/Subgroup #	Class	Enrollment Code	Student Status ✓ (A) Active
Dental	00055499-0001	A001	EBA	Name of School: University of Rochester Phone #:___________ Address:______________________________

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.

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. A Special Enrollment Period 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 Special Enrollment Period date. Please see your School 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 a Student/Subscriber (entire policy) using this Form:

- check Subscriber (S) box
- 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
- 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

SB02 – Left Employer/No Longer Eligible
SB05 – Per Group Request
SB09 – Enrolled in Error
SB07 – Subscriber Deceased
SB06 – Subscriber Request (voluntary)

Cancel Dependent Reasons

M001 – Per Group Request
M004 – Enrolled in Error
M002 – Deceased
M005 – Divorced
M003 – Per Subscriber Request
M007 – Per Member Request (voluntary)

FAMILY MEMBER QUALIFIED GUIDELINES: Use an additional form, if more than three persons.

- 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)
- **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 student has legal custody or legal guardianship, or a dependent who is claimed on student'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 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.
- **Gender and gender identity**: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge. 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
1-800-724-1675
TTY: 585-424-2845 or 1-800-662-1220