

Thank you for choosing BlueShield of Northeastern New York to provide your healthcare coverage. We look forward to having you as a member.

To enroll, you need to complete the attached Membership Enrollment Application and Change Form. We've included some brief instructions about how to complete this form. Please remember to **print using blue or black ink only, fill in all circles completely, and print one character per box when writing**. This will enable us to process your application timely and accurately.

At BlueShield of Northeastern New York, we are continuously working to provide you with quality care and service. We'd like to share with you some of the ways we do this:

- ✓ Our Concierge Service Program provides members with complete, comprehensive service. Our Customer Service Representatives are available to assist you in any way – answering benefit questions, looking up claims status or helping you to transfer your prescriptions to one of our participating pharmacies.

When you call about a claim issue, we'll look for other similar claims to make sure they have also been properly resolved. If you are having difficulty resolving an issue with a provider's office, we'll offer to call the provider for you. We review the reasons customers call us to determine what we can do to fix the root causes of the problem, so that other customers won't experience the same problem. Like a concierge in a four star hotel, we go above and beyond, so you know the situation will be taken care of with just one phone call.

- ✓ Members have access to health plan information 24 hours a day through our **web site at [www.bsneny.com](http://www.bsneny.com)**. While at the site, you can review the different health plans we offer; locate a provider who participates with your health plan; or search our drug formulary for quality, cost-effective medications.
- ✓ You can also use the *Click & Comment* feature of our web site to contact us day or night — whenever it's convenient for **you**. Simply click on the *Click & Comment* logo and you can provide feedback, ask a question or request information. We know you want answers fast, so a representative will respond to you within one business day.
- ✓ Our commitment to service can also be seen in our full certification from Customer Operations Performance Center, Inc. (COPC), an international mark of customer service excellence. Leading international firms such as Microsoft, Motorola, LL Bean and ClientLogic use COPC standards and we are proud to be **the only local health plan to achieve this certification**. COPC is 100% focused on making it easier for our customers to contact us and receive immediate resolutions when they have questions or need help.

Thank you again for choosing BlueShield of Northeastern New York!





## 4 – Subscriber Information

continued

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number (see directory)

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes  No

Do you have additional group health insurance?

Yes  No

Name of Prior Health Care Insurer

Policy Identification Number

Policy Effective Date

Policy Cancellation Date

## 5 – Dependent Information

Please provide all information for each person to be covered.

Spouse/Domestic Partner Last Name

Spouse/Domestic Partner First Name

M.I.

Social Security Number

Date of Birth

Male

Are you enrolling as a Domestic Partner?

Female

Yes  No

E-mail Address

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Part D Effective Date

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes  No

Do you have additional group health insurance?

Yes  No

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth

Male

Is your over-age dependent handicapped?

Female

(See instructions for additional information)  Yes  No

E-mail Address

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Part D Effective Date

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes  No

Do you have additional group health insurance?

Yes  No

# Additional Dependents Enrollment Application/Change Form

## 5 – Dependent Information continued

Please provide all information for each person to be covered.

Subscriber's Last Name

Subscriber's First Name

M.I.

Social Security Number

Date of Birth

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth

Male

Is your over-age dependent handicapped?

Yes

Female

(See instructions for additional information)

No

E-mail Address

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Part D Effective Date

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes

No

Do you have additional group health insurance?

Yes

No

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth

Male

Is your over-age dependent handicapped?

Yes

Female

(See instructions for additional information)

No

E-mail Address

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Part D Effective Date

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes

No

Do you have additional group health insurance?

Yes

No

## 5 – Dependent Information continued

Please provide all information for each person to be covered.

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth

Male

Female

Is your over-age dependent handicapped?  
(See instructions for additional information)

Yes

No

E-mail Address

Medicare Number (if applicable)

Part A Effective Date

Part B Effective Date

Part D Effective Date

Is dependent a full-time student?  Yes  No

If yes, please indicate college/university name:

College/University Name

Expected Graduation Date

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician Number

Are you a current patient, or If **not** a current patient, have you verified that the PCP will accept you as a new patient?

Yes

No

Do you have additional group health insurance?

Yes

No

### HMO/POS Coverage

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and;
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

### Traditional Indemnity Coverage

- If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective date of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
- We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.

## 6 – Disclosure / Signature

Subscriber signature required.

### Important: Please read and sign below:

\*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 CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION REQUESTED CONCERNING MEDICAL SERVICES I OR MEMBERS OF MY FAMILY HAVE RECEIVED, WHICH THE PLAN DETERMINES IS NECESSARY FOR THE OPERATION AND REGULATION OF THE PLAN. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

**X** Subscriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_