University of Rochester
Student Dental

Excellus
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			
❑ Add Subscriber (AA) Fall Quarter College Enrollment Date 9/01/12 Coverage Effective Date 9/01/12		Self, Spouse & Child(ren) (A) ❑	Self & Child(ren) (B) ❑	Self & Spouse (C) ❑	Self (D) ❑
❑ Add Dependent (AB) Event Date __/__/__ Coverage Effective Date __/__/__	✓ **Dental (DE)**				
❑ Change Coverage (AC) Coverage Effective Date __/__/__					
❑ Cancel Subscriber (S) ❑ Cancel Dependent (M) ❑ (D)ental Reason Code (see back) ________ 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.

	Social Security #	Sex	Birthdate (mm/dd/yy)
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other__________________ *Last Name (if different)* *First Name*		❑ M ❑ F	___/___/___
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other__________________ *Last Name (if different)* *First Name*		❑ M ❑ F	___/___/___
❑ (S)pouse ❑ (D)ependent ❑ Student(T) ❑ (H)disabled ❑ Other__________________ *Last Name (if different)* *First Name*		❑ M ❑ F	___/___/___

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 ✓ (A) Active
Dental	13997-501			Name of School:____________________ Address:____________________ 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
CP- Commercial
CB – Cobra Begin Date
CD – Cobra Disabled Date
CE – Cobra End Date
SR – Subscriber Request
SD – Subscriber Deceased
SB – Spouse's BCBS
MC - Medicaid

Cancel Dependent Reasons

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