



# Rochester Area Schools Health Plan 2 – Enrollment Form

P.O. Box 22999, Rochester, NY, 14692  
A nonprofit independent licensee of the BlueCross BlueShield Association

PLEASE PRINT CLEARLY District Name:  Group #:

## Section 1: Enrollment Information

### Type of Transaction Please X

Add Subscriber  \*Add Dependent  Remove Dependent  Change of Coverage  Change Gender  
 Change Name (prev. name \_\_\_\_\_)  Transfer to COBRA/COBRA Effective Date: \_\_\_\_\_

### Reason for Enrollment/Change

New Hire  Open Enrollment  Loss of Coverage  Retirement  Divorce  Other Coverage  
 Work Status Change

\*Add Dep. Reason:  Marriage – Date: \_\_\_\_\_  Newborn  Court Order  Domestic Partner

### Choose Plan:

Blue Point 2 Extended  Blue Point 2 Select  Blue Point 2 Value

### Type of Coverage:

Medical:  Single  Family  Subscriber & Spouse  Subscriber & Child  Family No Spouse

Hire Date: \_\_\_\_\_ Qualifying Event Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Subscriber Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F

### Mailing Address:

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

Home Phone Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Legally Separated

Medicare # (if applicable) \_\_\_\_\_ Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

Primary Care Physician Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

OB/GYN Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

## Section 2: Dependent Information

Spouse/Domestic Partner Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F

Primary Care Physician Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

OB/GYN Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Dependent's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F

Primary Care Physician Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

OB/GYN Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**Dental Only:** Full Time Student: Y N Expected Graduation Date: \_\_\_\_\_

<b>Dependent's Last Name:</b> _____		<b>First Name:</b> _____	
<b>Social Security Number:</b> _____ - _____ - _____	<b>Date of Birth:</b> ____ / ____ / ____	<b>Gender:</b> <b>M</b> <b>F</b>	
Primary Care Physician Last Name: _____	OB/GYN Last Name: _____	First Name: _____	First Name: _____
<b>Dental Only:</b> Full Time Student: <b>Y</b> <b>N</b>		Expected Graduation Date: _____	
<b>Dependent's Last Name:</b> _____		<b>First Name:</b> _____	
<b>Social Security Number:</b> _____ - _____ - _____	<b>Date of Birth:</b> ____ / ____ / ____	<b>Gender:</b> <b>M</b> <b>F</b>	
Primary Care Physician Last Name: _____	OB/GYN Last Name: _____	First Name: _____	First Name: _____
<b>Dental Only:</b> Full Time Student: <b>Y</b> <b>N</b>		Expected Graduation Date: _____	
<b>Dependent's Last Name:</b> _____		<b>First Name:</b> _____	
<b>Social Security Number:</b> _____ - _____ - _____	<b>Date of Birth:</b> ____ / ____ / ____	<b>Gender:</b> <b>M</b> <b>F</b>	
Primary Care Physician Last Name: _____	OB/GYN Last Name: _____	First Name: _____	First Name: _____
<b>Dental Only:</b> Full Time Student: <b>Y</b> <b>N</b>		Expected Graduation Date: _____	
<b>Section 3 Previous Coverage: If "Loss of Coverage" is selected, this section is REQUIRED.</b>			
Have you, your spouse or any enrolled dependent had other coverage within the last 63 days?		Health? <b>Y</b> <b>N</b>	Dental? <b>Y</b> <b>N</b>
If answering "Yes", are you keeping the additional health and/or dental coverage?		Health? <b>Y</b> <b>N</b>	Dental? <b>Y</b> <b>N</b>
Previous Insurance Carrier: _____	Name of Policy Holder: _____		
ID#: _____	Effective Date: ____ / ____ / ____	Termination Date: ____ / ____ / ____	
<b>Section 4 Release/Subscriber Signature Required. You must sign and date this form to be eligible for insurance.</b>			
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.			
<b>Subscriber Signature:</b> _____		<b>Date:</b> ____ / ____ / ____	
<b>Section 5 Group Employer Information</b> (This section should be completed by the Group Benefits Administrator. This application cannot be processed without this information and a Signature.)			
<b>Medical Group #:</b> 00044333	<b>Subgroup #:</b> 0002	<b>Class #:</b> ATTU	<b>Dept. Code:</b> _____
<b>Group Administrator Signature:</b> <i>Sue Forquell</i>		<b>Date:</b> ____ / ____ / ____	
<b>Subscriber Last Name:</b> _____			