



### **BCBS Individual Market**

Agency ID: 20360Amhe

Agency: AMHERST CHAMBER OF COMMERCE

**Effective Date:** 

PO Box 80, Buffalo, NY 14240-0080

Individual and Family Application/Change Form: Effective Date:

## 1—Instructions for Individual and Family Enrollment Application Form

Thank you for your interest in becoming a member of BlueCross BlueShield of Western New York. In order to process your membership, we need you to supply the information requested on this form.

- Using blue or black ink, please complete each applicable section.
- Please return the application with a check for the first full month's premium in the return envelope provided (check or money order ONLY; no cash please) so we can process your application.
- In the Plan Selection, plans identified with '\*' are available as child-only coverage.
- If you need assistance completing the application, please call 1 (716) 632-6905.
- Please return the completed application to:

Small Business Service of WNY c/o Amherst Chamber of Commerce 400 Essjay Rd Suite 150 Williamsville, NY 14221

2—Plan Selection		villiamsville, NT 14221		
Please use blue or black in	k, print one character per bo	x. Check applicable plan(s)	).	
Bronze Ind align	Silver Ind align	○ Gold Ind align ○	) Platinum Ind align	Blue Pediatric Dental **
Bronze Ind focus	<ul> <li>Silver Ind focus</li> </ul>	○ Gold Ind focus ○	) Platinum Ind focus	Blue Value Dental 1 **
Bronze Standard *	○ Silver Standard *	○ Gold Standard * ○	) Platinum Standard*	Blue Value Dental 2 **
	Silver Ind Destination 65	Gold Ind Destination 65		Blue Value Dental 3 **
Please Note: All medical plans	require selection of a Primary Car	re Physician (PCP). To find a PCP	, sign into <b>bcbswny.com</b> and	d select <i>my primary care doctor</i> .
Plan Selection Key: * available	e as child-only coverage **	Meets pediatric dental essential	health benefit requirement	
Payment Selection (check on	n <mark>e):</mark> ( ) Monthly ( ) Qu	uarterly		
3—Reason for Enrollment/Ch	lange			
Applicant, please indicate t	he reason for this enrollmen	nt or change.	THE PERSON NAMED IN	A STATE OF THE PARTY OF THE PAR
○ New Coverage ○ ○	Change Policy Coverage ()	Primary Care Physician	Remove Dependent	Loss of Coverage
Open Enrollment	Address/Phone Number	Last Name	Add Dependent(s) to	o Current Coverage
Add Dependent Please	indicate reason for adding depend	dent: O Newborn	Marriage	Loss of Coverage
4—Applicant Information	CT LLL	Adoption	O Domestic Partner	Change in Student Status
Please complete ALL sides	s of this application. The ap	plicant's signature is requ	ired in order to proces	s the application.
Applicant's Last Name		Applicant's	First Name	M.I.
Social Security Number	Date of Birth	(MMDDYY) Telephone	Number (include area cod	le) Gender: O Female
				◯ Male
Mailing Address	11	O	) Apt O Suite	Marital Status Single
				Married Divorced
City		State Zip Co	ode	Legally Separated
				Widowed
Email Address			Marital	Status Event Date (MMDDYY)
-	indicate reason for Medicare eligit			Renal Disease
Medicare Number (if applicable	;) Part A Effecti	we Date (MMDDYY) Part B Effecti	ive Date (MMDDYY) Part D.E	Effective Date (MMDDYY)
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BCBS104_052018 A division of F	HealthNow New York Inc., an indep	pendent licensee of the Blue Cros	ss and Blue Shield Association	on S

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Please provide all information for each pers		
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Social Security Number	Date of Birth (MMDDYY)	
Dependent's Last Name	Dependent's First Name	M.I.
Social Security Number	Date of Birth (MMDDYY) Gender: C Female Male	k J
	Is your over-age dependent handicapped? Yes	() No
Email Address		
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) Medicare Eligible Please indicate reason for M	fedicare eligibility: ( ) Age 65+ ( ) Disability ( ) End Stage Renal Disease	
Medicare Number (if applicable)	Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)	- - - - - - - - - - - - - - - - - - -
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Primary Care Physician's Last Name	Primary Care Physician's First Name	
Primary Care Physician ID#	1	
f you answered "no", we will provide coverage of the	he pediatric dental essential health benefit. Additional premium will apply.	
Dependent's Last Name	Dependent's First Name	M.I.
	Date of Birth (MMDDYY) Gender:	
Social Security Number		
Social Security Number	Is your over-age dependent handicapped?  Yes	O No
	Is your over-age dependent handicapped?  Yes	○ No
	Is your over-age dependent handicapped? Yes	O No
Email Address		() No
Email Address  Medicare Eligible Please indicate reason for M	Medicare eligibility: Age 65+ Disability C End Stage Renal Disease	
Email Address  Medicare Eligible Please indicate reason for M		
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Email Address  Medicare Eligible Please indicate reason for M Medicare Number (if applicable)  Primary Care Physician's Last Name	Medicare eligibility: Age 65+ Disability C End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)	
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Email Address  Medicare Eligible Please indicate reason for M Medicare Number (if applicable)  Primary Care Physician's Last Name  Primary Care Physician ID#  Are you a current patient, or if not a current patient.	Medicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  A part A Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  A part A Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  A part A Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  A part A Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  A part A Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name	
Email Address  Medicare Eligible Please indicate reason for M Medicare Number (if applicable)  Primary Care Physician's Last Name  Primary Care Physician ID#  Are you a current patient, or if not a current patient,  A. Have you obtained stand-alone dental coverage York State of Health, the Official Health Plan Ma	Medicare eligibility: Age 65+ Disability C End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name	ODYY)
Medicare Number (if applicable)  Primary Care Physician's Last Name  Primary Care Physician ID#  Are you a current patient, or if not a current patient, A. Have you obtained stand-alone dental coverage York State of Health, the Official Health Plan ManySOH?	Medicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  The	DDYY)
Email Address  Medicare Eligible Please indicate reason for M Medicare Number (if applicable)  Primary Care Physician's Last Name  Primary Care Physician ID#  Are you a current patient, or if not a current patient, A. Have you obtained stand-alone dental coverage York State of Health, the Official Health Plan MannySOH?	Medicare eligibility: Age 65+ Disability End Stage Renal Disease  Part A Effective Date (MMDDYY) Part B Effective Date (MMDDYY) Part D Effective Date (MMDDYY)  Primary Care Physician's First Name  It, have you verified that the PCP will accept you as a new patient?  Yes a that provides a pediatric dental essential health benefit through a New arketplace (NYSOH)-certified stand-alone dental plan offered outside the	ODYY)

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Dependent's Last Name						De	pendent'	s Fir	st N	ame								M.I.	
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Primary Care Physician's Last N	Name						Primary	y Ca	re Pl	nysic	ian's	First	Var	ne					
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Are you a current patient, or if n	ot a current p	patient, ha	ave yo	u verific	ed that	the PCI	P will acc	ept	you	as a	new p	atien	t?		0	Ye	s	0	N
A. Have you obtained stand-alo																			
York State of Health, the Off NYSOH?	icial Health P	Plan Marke	etplace	e (NYS	OH)-ce	rtified s	tand-alor	ne de	ental	plan	offer	ed ou	tsic	le the	0	Ye	s	0	N
3. If you answered "yes", pleas	e provide the	name of	the co	mpany	issuin	the sta	and-alone	e dei	ntal	cove	age.								
f you answered "no", we will pro	ovide coverag	ge of the p	pediatr	ric dent	tal esse	ntial he	alth bene	efit. /	Addi	iona	pren	nium	νiⅡ	apply.					
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# **PLEASE PRINT CLEARLY**

# Authorization to Use or Disclose Protected Health Information (PHI)

Part 1: Please print your name (the health plan member) and other information	ation requested below.
Member Name:	Date of Birth:
Address:	
Member ID #:	Telephone: ()
I authorize: to release my Ph	II as indicated below to the person(s)/entity(s) named
in Part 2. (Print name of health plan on identification card)	
Part 2: Print the name(s) of the authorized person(s) to whom the health p	lan may release your PHI.
Name:	Relationship:
Address:	Telephone: ()
Name:	Relationship:
Address:	Telephone: ()
Name:	Relationship:
Address:	Telephone: ()
Part 3: What PHI may the health plan release to the authorized person(s)?	
Any information or PHI in connection with any claim or appeal for coverage	
Benefits, premiums, eligibility, deductibles, etc.	
<ul> <li>Address or telephone number, date of birth, etc.</li> </ul>	
Medical records, hospital/prescription preauthorizations, referrals, etc.	
Other/special instructions:	W-6-12
Part 4: What actions may the authorized person(s) take in regard to your Pl	HI checked in Part 3?
The authorized person(s) may <b>discuss</b> my PHI in person, writing, or via phone	2.
The authorized person(s) may discuss and receive copies of my PHI (e.g., exp	planation of benefits, etc.).
The authorized person(s) may discuss, receive copies of, and make changes	to my PHI (e.g., PCP changes, address changes, etc.).
The authorized person(s) may do anything I am permitted to do.	
Part 5: By signing below, I understand I am authorizing the use/release of r	ny PHI and
1. My authorization is voluntary and not a condition of enrollment, eligibility, o	r claim payment;
2. The authorized person(s) may not be subject to federal/state privacy laws an	d they may further release my PHI;
3. I may revoke this authorization at any time by sending written notice; however taken in reliance on this authorization <b>prior</b> to the health plan's receipt of more than the sending written notice; however taken in reliance on this authorization <b>prior</b> to the health plan's receipt of more than the sending written notice; however taken in reliance on this authorization prior to the health plan's receipt of more than the sending written notice; however taken in reliance on this authorization prior to the health plan's receipt of more than the sending written notice; however taken in reliance on this authorization prior to the health plan's receipt of more than the sending written notice.	• • • • • • • • • • • • • • • • • • • •
4. This authorization replaces any HIPAA authorizations previously sent to the	nealth plan, unless checked here:
5. This authorization will expire in: (check one) one (1) year three from the date received by the health plan <b>OR</b> on expiration of the following (	e (3) years
See reverse side for important information regarding expiration date and previous	ously submitted authorizations.
Part 6: MEMBER OR PERSONAL REPRESENTATIVE SIGNATURE	
Print Name:	Relationship:
Signature	Date

# Authorization to Use or Disclose Protected Health Information (PHI)

### Why we are asking for your authorization

The Health Insurance Portability and Accountability Act (HIPAA), effective April 14, 2003, requires your express permission before we may discuss/release your protected health information (PHI) to your relatives, friends, employer, etc.

This authorization is needed to document your intent and to identify the person(s) who have your permission to contact us on your behalf ("authorized person") for claims status, benefit information, and/or other matters pertaining to your insurance coverage.

In most instances, HIPAA does not require your authorization before we may share your PHI with health care providers (e.g., physicians, hospitals, etc.) involved in your treatment or payment for your treatment. This exception is to ensure uninterrupted business operations, such as timely submission and processing of your claims for medical benefits. Therefore, it is **not** necessary to name your health care providers as authorized persons.

### How to use/complete this authorization

- Sensitive information/diagnoses: Do not use this form to request the release of HIV/AIDS information, mental health, and alcohol or substance abuse information. The required forms are 2(D) and 2(E) respectively, which are available online or by contacting Customer Service.
  - If you are using this form to authorize the release of *psychotherapy notes*, it must **only** be used for psychotherapy notes. You **must** use a separate 2A form to authorize the release of any other PHI.
- Part 1: This section should name the member of the health plan whose PHI will be shared with and/or disclosed to the authorized person(s).
- Part 2: This section should name the authorized person(s), such as a spouse or child, who will be contacting the health plan to discuss the member's PHI.
- Part 3: This section should indicate the specific PHI of the member that the health plan may share with and/or disclose to the authorized person(s).
- Part 4: This section is to identify how much authority you are giving the authorized person(s) to access and/or change
  your PHI. The default selection is marked with an 'X'. Mark any additional selections that apply.
- Part 5: Read this section carefully. Signing this form attests to all statements made in this section.
   IMPORTANT: (a) If the information is to be added to an authorization previously sent to the health plan, a checkmark must be made; otherwise, all previous information will be voided; (b) An 'indefinite', 'ongoing' or 'non-expiring' authorization will not be considered valid. This authorization will expire one (1) year from the date it is received if an expiration date is not specified.
- Part 6: The member's signature is required. If the member is incapable of signing due to illness, injury, or death, a personal representative (see below) may sign on the member's behalf.
  - A personal representative (PR), such as the parent of a minor child, power of attorney, or executor, may sign his or her name in the member's stead. The legal documents proving the authority of the PR to act for the member **must** be attached; otherwise, the PR's signature and this authorization will **not** be honored.
- Complete ALL sections: This authorization will be considered valid only if all sections are fully completed.

#### **Contact information**

PLEASE RETURN YOUR AUTHORIZATION FORM(S) TO THE ADDRESS LISTED BELOW.

If you have any questions or need assistance in completing this form, please call the Customer Service telephone number on the back of your identification card or write to:

Privacy Department PO Box 80 Buffalo, NY 14240

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