BlueCross BlueShield of Western New York

[redacted]

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

Please use blue or black ink, print one character per box. Check applicable plan(s).

◯ Bronze Ind align	◯ Silver Ind align	◯ Gold Ind align	◯ Platinum Ind align	◯ Blue Pediatric Dental **
◯ Bronze Ind focus	◯ Silver Ind focus	◯ 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 Care Physician (PCP). To find a PCP, sign into **bcbswny.com** and select *my primary care doctor.*

Plan Selection Key: * available as child-only coverage ** Meets pediatric dental essential health benefit requirement

Payment Selection (check one): ◯ Monthly ◯ Quarterly

3—Reason for Enrollment/Change

Applicant, please indicate the reason for this enrollment or change.

◯ New Coverage ◯ Change Policy Coverage ◯ Primary Care Physician ◯ Remove Dependent ◯ Loss of Coverage
◯ Open Enrollment ◯ Address/Phone Number ◯ Last Name ◯ Add Dependent(s) to Current Coverage
◯ Add Dependent Please indicate reason for adding dependent: ◯ Newborn ◯ Marriage ◯ Loss of Coverage
◯ Adoption ◯ Domestic Partner ◯ Change in Student Status

4—Applicant Information

Please complete ALL sides of this application. The applicant's signature is required in order to process the application.

Applicant's Last Name | Applicant's First Name | M.I.

Social Security Number | Date of Birth (MMDDYY) | Telephone Number (include area code) | Gender: ◯ Female ◯ Male

Mailing Address ◯ Apt ◯ Suite | Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Legally Separated ◯ Widowed

City | State | Zip Code

Email Address | Marital Status Event Date (MMDDYY)

◯ Medicare Eligible Please indicate reason for Medicare 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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4—Applicant Information continued

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician ID#

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

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health, the Official Health Plan Marketplace (NYSOH)-certified stand-alone dental plan offered outside the NYSOH? ○ Yes ○ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit. Additional premium will apply.

5—Dependent Information Please provide all information for each person to be covered.

Spouse/Domestic Partner's Last Name

Spouse/Domestic Partner's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: ○ Female ○ Male

Are you enrolling as a Domestic Partner? ○ Yes ○ No

Email Address

○ Medicare Eligible Please indicate reason for Medicare 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)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician ID#

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

Dependent's Last Name

Dependent's First Name

M.I.

Social Security Number

Date of Birth (MMDDYY)

Gender: ○ Female ○ Male

Is your over-age dependent handicapped? ○ Yes ○ No

Email Address

○ Medicare Eligible Please indicate reason for Medicare 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)

Primary Care Physician's Last Name

Primary Care Physician's First Name

Primary Care Physician ID#

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

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health, the Official Health Plan Marketplace (NYSOH)-certified stand-alone dental plan offered outside the NYSOH? ○ Yes ○ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit. Additional premium will apply.

5—Dependent Information continued

Please provide all information for each person to be covered.

Applicant's Last Name | Applicant's First Name | M.I.

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: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

Email Address

◯ Medicare Eligible Please indicate reason for Medicare 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)

Primary Care Physician's Last Name | Primary Care Physician's First Name

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B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit. Additional premium will apply.

Dependent's Last Name | Dependent's First Name | M.I.

Social Security Number | Date of Birth (MMDDYY) | Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

Email Address

◯ Medicare Eligible Please indicate reason for Medicare 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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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 (MMDDYY) | Gender: ◯ Female ◯ Male

Is your over-age dependent handicapped? ◯ Yes ◯ No

Email Address

◯ Medicare Eligible Please indicate reason for Medicare 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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B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage.

If you answered "no", we will provide coverage of the pediatric dental essential health benefit. Additional premium will apply.

6—Agent/Broker Certification

To be completed by your BlueCross BlueShield of Western New York appointed agent/broker:

Did you see the proposed applicant and spouse/domestic partner, if applying, at the time this application was executed? Yes No

If NO, please explain:

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **Date**

X

Agent/Broker Name (please print)		**Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.**	
Small Business Services of WNY		**400 Essjay Rd Suite 150**	
Agent/Broker ID/TIN	**Agency ID/Parent TIN**	**City**	**State Zip**
	LB-1470543	**Williamsville, NY 14221**	
Agent/Broker Phone Number	**Agent/Broker Fax No.**	**Agent/Broker Email Address**	
(716) 632.6905	**(716) 632.0548**	**healthinsurance@amherst.org**	

Important Notice

I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION OR DOCUMENTS 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 AND IS VALID FOR UP TO 24 MONTHS.

*** 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.**

X

Signature of Applicant **Date**

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 requested below.

Member Name: _____ Date of Birth: _____

Address: _____

Member ID #: _____ Telephone: (____) _____

I authorize: _____ to release my PHI 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 plan 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 or benefits, **including but not limited to**:

- Benefits, premiums, eligibility, deductibles, etc.
- Address or telephone number, date of birth, etc.
- Medical records, hospital/prescription preauthorizations, referrals, etc.

☐ Other/special instructions: _____

Part 4: What actions may the authorized person(s) take in regard to your PHI checked in Part 3?

☒ The authorized person(s) may **discuss** my PHI in person, writing, or via phone.

☐ The authorized person(s) may **discuss and receive copies** of my PHI (e.g., explanation 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 my PHI and

1. My authorization is voluntary and not a condition of enrollment, eligibility, or claim payment;
2. The authorized person(s) may not be subject to federal/state privacy laws and they may further release my PHI;
3. I may revoke this authorization at any time by sending written notice; however, revocation will not affect any action previously taken in reliance on this authorization **prior** to the health plan's receipt of my revocation;
4. This authorization **replaces** any HIPAA authorizations previously sent to the health plan, unless checked here: ☐
5. This authorization **will expire** in: **(check one)** ☐ one (1) year ☐ three (3) years ☐ five (5) years from the date received by the health plan **OR** on expiration of the following (e.g., litigation): _____

See reverse side for important information regarding expiration date and previously 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

Amherst Chamber of Commerce

...Servicing Your Health Insurance Needs

Dear Insurance Subscriber,

Thank you for your support of the Amherst Chamber of Commerce. We are pleased to provide you with our knowledge and expertise as you navigate the changes in the health insurance delivery system.

You have selected _____ as your plan beginning January 1, 2022 and authorize the Amherst Chamber of Commerce to act as your billing agent.

_____

Signature

_____

Printed Name

_____

Date