

2017 New Group Enrollment Form



BlueShield
of Northeastern New York

Effective date _____
Company name as it appears on NYS-45 _____
Tax ID _____
Address _____
City _____
State _____ Zip _____ County _____
Phone number _____ Fax number _____

The company must have employees who live, work, or reside in our service area.

Company set-up

Your employees will be categorized as Active, COBRA and Retiree. If you need additional categories, please list them below.

Additional categories _____

Waiting period for new employees 0 days 30 days 60 days 90 days

Contribution

Please include company contributions (percentage or flat dollar amount) to premium by the category you have selected above: Active, COBRA, Retiree, and others specified by you. (There are no minimum employer contribution requirements.)

Active

Single _____
2-Person _____
Emp/Child _____
Family _____

COBRA

Single _____
2-Person _____
Emp/Child _____
Family _____

Retiree

Single _____
2-Person _____
Emp/Child _____
Family _____

Category Name

Single _____
2-Person _____
Emp/Child _____
Family _____

Category Name

Single _____
2-Person _____
Emp/Child _____
Family _____

Category Name

Single _____
2-Person _____
Emp/Child _____
Family _____

Will employees receive the unused funds from the contribution? Yes No

How often are your employees paid? Weekly Bi-weekly Semi-monthly

Additional company information

Total number of employees _____ Average number of employees _____

Total number of eligible employees _____ Total number of full time equivalents _____

Group size will only be based on the number of full-time equivalent employees of the employer in the previous calendar year.

Employees eligible for health insurance coverage are part-time and full-time employees that work 20 or more hours per week.

Were you offered dependent coverage? Yes No Not applicable

Were you offered dependent coverage to age 29? Yes No Not applicable

Do you need an HRA and/or FSA? HRA FSA Do not need HRA or FSA

Do you need a Direct Bill COBRA group? Yes No

Do you need pre-enrollment kits? Yes No

If yes, how many? _____

When do you need the kits by? _____

Send kits to whose attention? _____

A division of HealthNow New York Inc., an independent licensee of the BlueCross BlueShield Association.

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Do you need group Medicare coverage? Yes No

Is BlueShield of Northeastern New York your sole carrier? Yes No If No, please list additional carriers below:

Who is your prior insurance carrier? _____

Contact information

Is your mailing address different than your physical address? Yes No

If yes, please include the address

Address _____

City _____ State _____ Zip _____

Group contact name _____

Group contact email address _____

Group contact phone number _____

Is the group contact the owner/decision maker? Yes No

If not, please indicate the decision maker name: _____

Decision maker email address _____

Decision maker phone number _____

Is your billing address different than your physical address? Yes No

If yes, please include the address

Address _____

City _____ State _____ Zip _____

Billing contact name _____

Billing contact email address _____ Billing contact phone number _____

How often would you like to be billed? Monthly Quarterly Semi-annually

Do you have a union? Yes No

If yes, please indicate the union name(s): _____

What is your industry type? _____

ERISA Information

ERISA plan year: _____

ERISA contact: _____

Plan: _____

Phone number: _____

I certify that all of the information furnished on this form is current, true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person who 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 subject to a civil penalty not to exceed \$5,000 and that stated value of the claim for each such violation.

Group Administrator Signature: _____

Date: _____