2020 New Group Enrollment Form

BlueCross BlueShield of Western New York

Effective Date

Plan Offerings

Company name as it appears on NYS-45

TaxID SIC Code

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 (SECTION NOT REQUIRED IF NOT USING OUR ENROLLMENT TOOL FOR MEMBER ENROLLMENT)

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		**COBRA**		**Retiree**	
Single		Single		Single	
2-Person		2-Person		2-Person	
Emp/Child		Emp/Child		Emp/Child	
Family		Family		Family	

_____		_____		_____	
Category Name		Category Name		Category Name	
Single		Single		Single	
2-Person		2-Person		2-Person	
Emp/Child		Emp/Child		Emp/Child	
Family		Family		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? _____

Do you need group Medicare coverage? ☐ Yes ☐ No

Is BlueCross BlueShield of Western 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?

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: