



PO Box 15013, Albany, NY 12212-5013 **Enrollment Application/Change Form — SMALL** Please use blue or black ink, print one character per box. Subscriber Status: Active Retired **COBRA** Please indicate reason for COBRA: Group # Subgroup # Class # Left Employ / Retirement Death of Spouse Divorce/Legal Separation Dependent Reached Max Age **Employer Name** Loss of Student Status Other Effective Date (MMDDYY) COBRA Effective Date (MMDDYY) Association/Chamber Name (if applicable) Hire/Rehire Date (MMDDYY) Retired Effective Date (MMDDYY) Group Administrator Signature / Date Subscriber Plan Section Please use blue or black ink, print one character per box. Check applicable plan(s). Plan Number: **PCP** Specialist \$ Please indicate copay: Single or Family: POS **POS Plus** Dental **HMO Plus** Please choose coverage type Medical Traditional Vision EPO Other Aqua Dental Vision A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? 🔘 Yes O 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. New Hire COBRA Primary Care Physician Remove Dependent Loss of Coverage Open Enrollment Address/Phone Number Last Name Retirement Add Dependent Please indicate reason for adding dependent: Newborn Marriage Loss of Coverage Adoption **Domestic Partner** Change in Student Status Subscriber's Last Name Subscriber's First Name M.I. Social Security Number Date of Birth (MMDDYY) Telephone Number (include area code) Gender: Female O Male Mailing Address Apt Suite Marital Status Single Married Divorced City Zip Code State Legally Separated Widowed E-mail Address Marital Status Event Date (MMDDYY) Medicare Eligible Please indicate reason for Medicare eligibility: O 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) -over-CN9XAN0474 BS 05-2014 F10982 A division of HealthNow New York Inc. An independent licensee of the BlueCross BlueShield Association.

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