



PO Box 80, Buffalo, NY 14240-0080

1—Group Employer Information Enrollment Application	on/Change Form
This section should be completed by the Group Benefits Administrator.	
This application cannot be processed without this information and a signa	ature.
Please use blue or black ink, print one character per box	Subscriber Status:
Group # Subgroup # Class #	Active Retired COBRA
	Please indicate reason for COBRA:
Employer Name	Left Employ / Retirement Death of Spouse
	Divorce/Legal Separation Dependent Reached Max Age
Association/Chamber Name (if applicable)	Coss of Student Status Other
	Effective Date (MMDDYY) COBRA Effective Date (MMDDYY)
Group Administrator Signature / Date	
	Hire/Rehire Date (MMDDYY) Retired Effective Date (MMDDYY)
2—Subscriber Plan Section	
Please use blue or black ink, print one character per box. Check applicable	e plan(s).
Plan Number: Please indicate copay: PCP \$	Specialist \$ Modical S F
POS POS Plus Dental HMO HMO Plus PPO Traditional Vision PPO Agua Q	Please choose coverage type Medical S F
PPO Traditional Vision EPO Aqua (Other Single or Family: Dental S F
	Vision S F
3—Reason for Enrollment/Change	
Subscriber, please indicate the reason for this enrollment or change.	
Subscriber, please indicate the reason for this enrollment or change. O New Hire O COBRA O Primary Care	
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name	Retirement
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newton	Retirement born Marriage Loss of Coverage
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop	Retirement born Marriage Loss of Coverage tion Domestic Partner Change in Student Status
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newtone Address Adop Please complete both sides of this application. The subscriber signature is required.	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application.
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop	Retirement born Marriage Loss of Coverage tion Domestic Partner Change in Student Status
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newtone Address Adop Please complete both sides of this application. The subscriber signature is required.	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application.
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newto Adoperate Information Adoperate English Subscriber S	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I.
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newto Adoperate Information Adoperate English Subscriber S	Retirement born Marriage Loss of Coverage tion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newth	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female - Male
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newth	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced Expression Student Status Married Divorced Legally Separated Widowed
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced a Zip Code Legally Separated
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State E-mail Address	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced e Zip Code Legally Separated Widowed Marital Status Event Date (MMDDYY)
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State E-mail Address Medicare Eligible Please indicate reason for Medicare eligibility: Age 6	Retirement Dorn Marriage Loss of Coverage Stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Marriad Divorced Expanding Status Event Date (MMDDYY) Marrial Status Event Date (MMDDYY) Marrial Status Event Date (MMDDYY) Marrial Status Event Date (MMDDYY) End Stage Renal Disease
Subscriber, please indicate the reason for this enrollment or change. New Hire COBRA Primary Care Open Enrollment Address/Phone Number Last Name Add Dependent Please indicate reason for adding dependent: Newt 4—Subscriber Information Adop Please complete both sides of this application. The subscriber signature is require Subscriber's Last Name Social Security Number Date of Birth (MMDDYY) Mailing Address City State E-mail Address Medicare Eligible Please indicate reason for Medicare eligibility: Age 6	Retirement born Marriage Loss of Coverage stion Domestic Partner Change in Student Status red in order to process the application. Subscriber's First Name M.I. Telephone Number (include area code) Gender: Female Apt Suite Marital Status Single Married Divorced e Zip Code Legally Separated Widowed Marital Status Event Date (MMDDYY)

4—Subso	cribe	r Info	orm	atio	n co	ontin	ued																						
Primary Car	e Phy	sician'	s Las	st Nar	me									Prir	nary	/ Car	e Pl	hysic	ian's	Fire	st Na	me				,			
Primary Car	e Phy	sician	Num	ber				,			Are y	ou a	curre	ent pa	atien	ıt, or i	f not	a cu	rrent	patie	nt, h	ave							
											you	verifie	ed tha	at the	PCF	P will a	acce	ept you	u as	a nev	v pati	ient?		\circ	Yes	3	\bigcirc	No	
Name of Pri	or Hea	alth Ca	are In	surer							С	Оо ус	ou ha	ave a	ddit	iona	l gro	oup h	ealtl	n ins	uran	ice?		0	Yes	3	\bigcirc	No	
Policy Identi	ficatio	n Nun	nber											Poli	cy Ef	fectiv	e Da	te (Mi	MDD	YY)		Pol	icy C	ancell	lation	Date ((MMI	DDYY	7
5—Deper	nden	t Info	orma	atio	n Ple	ase p	orovido	e all	info	rmat	ion	for e	ach	pers	son	to b	e cc	vere	ed.										
Spouse/Don	nestic	Partne	er's L	ast N	lame						Т			Spc	use	/Dor	nest	tic Pa	artne	r's F	irst l	Nam	e				Т	M.I.	
Social Secu	rity Nu	ımber						Dat	e of E	3irth (MMD	DYY)		0	Ма	le		Are	you	enro	olling	as a	Don	nestic	ı c Partı	ner?		
	<u>.</u> Г		٦.												Ó	Fen	nale			-		J			\bigcirc	Yes			No
E-mail Addr	ı ∟ ress		_	ш				_						I															
																						Т	Т						
Medicare	 ≤ Fliaih	le Ple	asa ii	ndica	te rea	son f	or Mad	icare	م وازم	ihility		\Box	Δαε	e 65+			Die	sabili	tv		Fn/	d Sta	ne P	enal [Disea				
Medicare Nu	-				10a	JUI 1	OI IVICU		-	-		<u> </u>	_			U tBF			•	U MDD			_			ise te (MN	יחחו/	YY)	
WICHIGAIG INC	ai i i i i i i	(11 app	Jiical	,ic)				ı al		ICCIIV	u ual	w (ivil	טטוי	, ı , 	ıaı	اتا د ،	iicul\	ve Da	الاا) ت	טטוייו		ı d	ם טוו		Dal	~ (IVIIV	טטוי	,	
Primary Car	ρ Phu	sician'	e Lac	et Nor	me									ı l	Dri	marr	, Car	re Ph	l Weig	ian'r	Fire	L No	mo						
Filliary Car	e Fily:	Sician	S Las	ot inai	ne	Т									FIII	Пагу	Cal	le Fi	iysic	lans	FIIS	SUINA	IIIE	Т					
Drimanı Car	a Dhu	ninian	Nima	har							۸۳۵				otio		if no	t o o		l noti	ont b								
Primary Car	e Phy	sician	Num	ber				1				•		•				ept you		•				\bigcirc	Yes	e	\bigcirc	No	
Name of Dai		141- 0-	!					J																					
Name of Pri	or nea	aith Ca	are in	Surer							L	JO yc	ou na	ave a	iaaii	lona	gro	oup h	eaiu	i ins	uran	ice?	Т	Γ	Yes	5	\cup	No	
																	_							<u> </u>]				_
Policy Identi	ficatio	n Nun	nber											Polid	cy Ef	fectiv	e Da	te (Mi	MDD	YY)]		Po	icy C	ancell	ation	Date ((MMI	DDYY	')
																										Ш			
Dependent's	s Last	Name												Der	end	dent's	s Fir	st Na	ame									M.I.	
																							Π						
Social Secu	rity Nı	ımher						Dat	e of F	Birth (ММГ	DYY	 ገ		\bigcirc	Ma	le.		s voi	ır ove	er-an	ne de	nend	lent h	nandi	j icappe	-d?	$\overline{}$	Yes
			7						0 01 1	J. u. (VIIVI		,		\bigcirc		nale		•		·		•			ormati		$\tilde{}$	No
E-mail Add			J -											l		, 01	. 1010		,500	101	30HU		uul		II II O	····au	J. 1)		0
E-mail Addr	೮೪೪		1															Т				Т	Т	Т					$\overline{}$
NA - P -	, F":-"	lo C'	<u> </u>	. دالم	to ==	25.5	N.4 '	ia	- ام	ikilir		\sqsubseteq	Λ				L.	 	<u> </u>			۲۰,		05-15):c::				
Medicare No.	_				ıe rea	son t	or ivied		_	-		<u> </u>	_	e 65+		· D =		sabili	•				_	enal [1D.C.		
Medicare Nu	umber	(іт арр	olicat	ne)				Par	t A Ef	iectiv	e Dat	e (Mi	AIDD,	YY)	Par	t R FJ	necti\	ve Da	ie (M	IVIDD	(YY	Pa	πDE	:ITECTIV	⁄e ∪at	te (MN	טטוע)	YY)	
						$\overline{\perp}$		\sqsubseteq	<u> </u>			L		l l		<u></u>		<u></u>	_							Ш			
Is dependen				ent?	(U Y	'es	\bigcirc	No			If ye	es, p	leas	e ind	dicat	e co	llege	/uni	/ersi									
College/Univ	versity	Name	Э																	1	Exp	pecte	d Gra	aduatio	on Da	ate (Mi	MDD	YY)	
Primary Car	e Phy	sician'	s Las	st Nar	me								l		Pri	mary	Ca	re Ph	nysic	ian's	Fire	st Na	me			1			
Primary Car	e Phy	sician	Num	ber		,	,	1			Are	you a	a cun	rent p	atier	nt, or	if no	t a cu	ırren	t patie	ent, ł	nave							
											you	verifie	ed tha	at the	PCF	P will a	acce	ept you	u as	a nev	v pati	ient?		\bigcirc	Yes	3	0	No	
Name of Pri	or Hea	alth Ca	are In	surer				_				Оо ус	ou ha	ave a	ddit	iona	l gro	oup h	ealtl	n ins	uran	ice?			Yes	s	0	No	
Policy Identi	ficatio	n Nur	nber				1							Polid	cy Ef	fectiv	e Da	te (Mi	MDD	YY)		Pol	icy C	ancell	ı lation	Date ((MMI	ODYY	7
			1												,]			,, ,						, over-
														ш						J						ш			***

Additional Dependents

Enrollment Application/Change Form

5 Donondont Inf	ormation	:	Linon	ment Ap	pnicat	.ioii/oilailige	. 51111			
5—Dependent Info Please provide all info		_	be covered							
Subscriber's Last Name		. po.oo.ii to k			Subscri	iber's First Name	e			M.I.
Subscriber 3 East Name					Oubscri	IDOI 3 I II 3C I VAIII				101.11.
Social Cooumity Number			Data of Dieth (MM)							
Social Security Number	1 [Date of Birth (MIV	(זייטטו						
] - [
Dependent's Last Name)				Depend	dent's First Nam	e			M.I.
									7	
Social Security Number			Date of Birth (MIV			Male Is y	our over-age de	enendent han	dicanned?	Yes
Josial Geodity Hamber			Date of Biran (IVIIV				ee instructions f			O No
] - [remale (Se	e ilistructions i	oi additionalii	iioimauon)	U NO
E-mail Address										
Medicare Eligible Ple	ease indicate reaso				e 65+	Disability		tage Renal D		
Medicare Number (if ap	plicable)	P.	Part A Effective D	ate (MMDD)	YY) Par	rt B Effective Date (MMDDYY) Pa	art D Effective D	Date (MMDD	YY)
s dependent a full-time	student?	Yes (No	If yes, p	lease inc	dicate college/ur	niversity name	e :		
ollege/University Nam	е						Expecte	ed Graduation I	Date (MMDD	YY)
rimary Care Physician	's Last Name				Pri	mary Care Phys	ician's First N	ame		
rimary Care Physician	Number		Are	e you a cur	rent patier	nt, or if not a curre	ent patient, have)	_	
			you	u verified tha	at the PCF	P will accept you a	s a new patient?	? O Y	es O	No
lame of Prior Health Co	are Insurer			Do vou ha	ave addit	tional group hea	Ith insurance?	O Y	es (No
				T		<u> </u>		П		
olicy Identification Nur	nher				Policy Ef	ffective Date (MMD	DVV) Pr	olicy Cancellation	n Date (MM	
Olicy Identification (Val					1 Olicy Li	IICCUVC DAIC (IVIIVID		Jicy Gai locilatio	JI Date (IVIIVI	
Dependent's Last Name	<u>,</u>				Depend	dent's First Nam	e			M.I.
populacine a East Hame					Бороно	JOHES FIRST VAIN				141.1.
Social Socurity Number			Octo of Pirth (MM)			Mala	rour over age de	nondont han	diaannad2	O Von
Social Security Number			Date of Birth (MM	(נות חחו		•	our over-age de	•		O No
] - [Female (Se	ee instructions f	oi auditional ir	แบกกลนอก)	O No
E-mail Address				 					 	
Medicare Eligible Ple					e 65+	Disability		tage Renal D		
Medicare Number (if ap	plicable)	P.	Part A Effective D	ate (MMDD)	YY) Par	rt B Effective Date (MMDDYY) Pa	art D Effective D	Date (MMDD	YY)
s dependent a full-time	student?	Yes (No	If yes, p	lease ind	dicate college/ur	niversity name) :		
College/University Nam	e						Expecte	ed Graduation I	Date (MMDD	YY)
rimary Care Physician	's Last Name				Pri	mary Care Phys	ician's First N	ame		
Primary Care Physician	Number		Are	e you a cum	rent patier	nt, or if not a curre	ent patient. have		_	
, , , , , , , , , , , , , , , , , , , ,				•	•	P will accept you a	•		es 🔘	No
lame of Prior Health C	are Insurer					tional group hea	•	_	es (No
I I I I I I I I I I I I I I I I I I I	2.5 11100101			20 you ne	avo addit	iionai group nea	modranoe:	т і		. 10
	-1				D. F. 51	S	D) 0 0 =		- D-1 (***	DD\
Policy Identification Nur	nper	 			Policy Ef	ffective Date (MMD	יטיא) Po	olicy Cancellatio	on Date (MM	UUYY)
						1 1 1 1				

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) Male Is your over-age dependent handicapped? O Yes
Female (See instructions for additional information) No
E-mail 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)
Tatt Lineare Pale (WiNDSTT) Tatt S Lineare Pale (WiNDSTT)
le dependent a full time atudent?
Is dependent a full-time student? Yes No If yes, please indicate college/university name:
College/University Name Expected Graduation Date (MMDDYY)
Primary Care Physician's Last Name Primary Care Physician's First Name
Primary Care Physician Number (see directory) 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
Name of Prior Health Care Insurer Do you have additional group health insurance? Yes No
Policy Identification Number Policy Effective Date (MMDDYY) Policy Cancellation Date (MMDDYY)
 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and; Treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under thin.
plan. If you would like more information on WHCRA benefits, call your Plan Administrator.
 Traditional Coverage If you chose Traditional coverage, your contract may include waiting periods for pre-existing conditions. This means we will not pay for any service related to conditions for which you received advice, diagnosis or treatment during the six months immediately preceding the effective da of coverage. Benefits will become available for services related to pre-existing conditions when your contract has been in effect for eleven (11) months.
 We will credit the time you were covered under any other creditable coverage toward the waiting periods for a pre-existing condition on this contract, provided there was no break in coverage greater than 63 days between the termination of the previous creditable coverage and the effective date of your new contract.
6—Disclosure / Signature
Subscriber signature required.
Important: Please read and sign below: *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.
I AUTHORIZE ANY LICENSED DOCTOR, HOSPITAL OR OTHER HEALTH CARE PROVIDER TO PROVIDE MY PLAN WITH ANY INFORMATION 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.
Subscriber Signature Date