Documentation Required for Verifying Dependent Eligibility

Below is a list of the documents required to verify the eligibility of dependents enrolling in the health plan. In most cases, at least TWO forms of documents are required per dependent. Please read carefully, review the appropriate documentation, check the corresponding boxes, and sign and date at the bottom of the form. There is no need to keep copies of the supporting documentation. Retain this document with the district's copy of the application.

Employee Name ____

DEPENDENT TYPE

Legal Spouse

Document Options for Verifying Eligibility (any one of the following document sets):

- ☐ Copy of the marriage certificate and federal tax return within last 2 years listing spouse
- ☐ Copy of the marriage certificate and proof of joint ownership or residency issued within last 6 months
- ☐ Copy of the marriage certificate only (if married in the last 12 months)

Biological Child

Document Options for Verifying Eligibility (any one of the following documents):

- ☐ Copy of the child's birth certificate (including parents' names)
- ☐ Non-government-issued birth Certificate (including child's name, date of birth and parents' names) if 3 months and under

Step-Child

Documents for Verifying Eligibility: (all of the below documents are required):

- ☐ A sworn and notarized statement that the subscriber's spouse is the parent of the child
- ☐ Copy of the child's birth certificate and a copy of the marriage certificate to establish the relationship to the subscriber as a stepparent
- ☐ The QMSCO Certification Form and copy of the court order, when applicable

Newborn Proposed Adopted Child

Documents for Verifying Eligibility (both of the following documents are required):

- ☐ A copy of the 115-c petition
- ☐ Proof that the subscriber has physical custody of the child upon discharge from the hospital or birthing center

Non-Newborn Proposed Adopted Child

Documents for Verifying Eligibility (both of the following documents are required):

- ☐ A statement from the adoption agency or in a case of private adoption, other appropriate documentation indicating that the subscriber is the proposed adoptive parent and the approximate or target date of adoption
- ☐ Proof that demonstrates the proposed adoptive child is dependent upon the subscriber during the waiting period prior to the adoption becoming final

  ***Documentation for <u>foreign</u> proposed adoption include documentation similar to the above, and a copy of both the original and translated documents.**

Adult Child Incapable of Self-Sustaining Employment[1]

Documents for Verifying Eligibility: (both of the following documents are required):
- ☐ A completed Disabled Dependent Form
- ☐ Proof of financial dependency

Legal Guardianship

Document for Verifying Eligibility:
- ☐ A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or court orders do not convey legal guardianship. Custody alone is not sufficient. Court order must specifically confer legal guardianship. The child is eligible for coverage on the date of the court order.

Qualifying Event: ______________________________

Names of Verified Dependents: ______________________________

Effective Date of Coverage: ______________________________

______________________________ ______________________________
Group Administrator Signature [2] Date

---

[1] Child must meet several conditions to qualify. Please refer to list of qualifications in Administrator Guide.

[2] Signature acknowledges that the employee provided the required documentation to verify the dependents listed on this form. Completion of this form does not guarantee enrollment in the Excellus plan. All enrollments in the plan are subject to Excellus approval.

Excellus BCBS: Classic Blue

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 09/01/2020 - 08/31/202

Coverage for: Family | **Plan Type:** Tradition

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. Fo general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$50 Individual/$100 Two Person/$150 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$450 Individual/$900 Two Person/$1,350 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in thi plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	$10/prescription retail, $20/ prescription mail order Deductible does not apply	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription
	Tier 2 (Preferred brand drugs)	$25/prescription retail, $50/ prescription mail order Deductible does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$40/prescription retail, $80/ prescription mail order Deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need immediate medical attention	Emergency room care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Emergency medical transportation	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Urgent care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible does not apply	No Charge Deductible does not apply	None N/A None limit
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Inpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you are pregnant	Office visits	No Charge Deductible does not apply	No Charge Deductible does not apply	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Childbirth/delivery facility services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need help recovering or have other special	Home health care	No Charge Deductible does not apply	No Charge Deductible does not apply	60 Visits per year limit

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
health needs	Rehabilitation services	20% Coinsurance	20% Coinsurance	100 Visits per year limit
	Habilitation services	20% Coinsurance	20% Coinsurance	100 Visits per year limit
	Skilled nursing care	No Charge Deductible does not apply	No Charge Deductible does not apply	100 Days per year limit
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None
	Hospice services	No Charge Deductible does not apply	No Charge Deductible does not apply	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Child)
- Routine eye care (Adult)
- Weight loss programs
- Cosmetic surgery
- Hearing aids
- Routine eye care (Child)
- Dental care (Adult)
- Long-term care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Private-duty nursing
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security

Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$50**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$50**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$170
Coinsurance	$130
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$410**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$50**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$170**

The plan would be responsible for the other costs of these EXAMPLE covered services.

FOR INTERNAL USE ONLY

HIOS ID# ____________

EC ____________

Excellus National strength Local focus. Individual care.

A nonprofit independent licensee of the Blue Cross Blue Shield Association

CONFIDENTIAL

Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information To be completed with your Group Administrator

Cincinnatus Central School District — Employer Name

COOPERATIVE HEALTH INSURANCE FUND — Association/Chamber Name (if applicable)

Group Administrator's Signature (required) ____________ Date ____________

Employee Number ____________ Department Number ____________

Medical Information

00063224 — Medical Group Number (8 digits)

Medical Subgroup Number (4 digits) ____________

Medical Class Number (4 digits) ____________

If enrolling in a Medical plan, who do you need coverage for?
☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

____ /____ /____
Medical Effective Date

Subscriber Status:
☐Actively Working
☐Retired
☐Disability
☐Canceled
☐COBRA

Dental Information

Dental Group Number ____________

Dental Subgroup Number ____________

Dental Class or Package # ____________

If enrolling in a Dental plan, who do you need coverage for?
☐Self Only
☐Self & Child(ren)
☐Self & Spouse, or Self & Domestic Partner
☐Family

____ /____ /____
Dental Effective Date

Medical Plan Selection

☐ (DKC) Classic Blue
☐ (AVM) Classic Blue
☐ (XB) Classic Blue
☐ (DBH) Signature Deductible 3
☐ (CDZ) Classic Blue
☐
☐
☐

Dental Plan Selection

☐ (DE) Dental

Section 2: Subscriber's Information

Last Name ____________

First Name ____________

Middle Initial ____________ **Title (e.g., Jr, Sr, III, etc.)** ____________

Street Address ____________

City ____________ **State** ____________

Zip Code ____________ **Phone** ____________

Birthdate: ____ /____ /____

Gender:
☐Male
☐Female

Social Security Number** ____________

Date of Hire/Rehire: ____ /____ /____

Retire Date: ____ /____ /____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced Marital Status Event Date: ____ /____ /____

Subscriber's Medicare Number (if applicable) ____________

☐Age 65+ ☐Disability ☐End Stage Renal *

____ /____ /____ **Part A** Effective Date

____ /____ /____ **Part B** Effective Date

Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancelations

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment ☐Medicare eligible

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other ______________
☐Change in employment status ☐A move in or out of the service area
☐Involuntary loss of coverage ☐Former dependent regains eligibility **Date of Event** ___ /___ /______

COBRA Election - Please indicate the reason for COBRA if applicable:
☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Spouse
☐Disability ☐Dependent Reached Max Age ☐ Other: ______________________________

Demographic Change: ☐Address ☐Birthdate ☐Subscriber Name ☐Dependent Name ☐Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber

Cancel Code:	Medical Cancel Date:	Dental Cancel Date:
	/ /	/ /

Cancel Codes:
SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request (voluntary) SB07-Deceased SB09-Enrolled in Error

Dependent(s)

Dependent Name:	Cancel Code:	Medical Cancel Date:	Dental Cancel Date:
		/ /	/ /
		/ /	/ /
		/ /	/ /

Cancel Codes:
M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request (voluntary) M011-No Longer a Student M040-Mx Same Group

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required)
☐Other ______________________

Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender:
☐Male ☐Female **Birthdate** ______ /______ /_________

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university ______________________________ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

__________________________ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

↓ Additional Dependent(s) ↓

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title **First Name** MI **Social Security Number** **

Gender:
☐Male ☐Female **Birthdate** ______ /______ /_________

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university ______________________________ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

__________________________ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other ____________________

Last Name (if different) ______ Title ______ **First Name** ______ MI ______ **Social Security Number** ** ______

Gender:
☐Male ☐Female **Birthdate** ______ /______ /__________

Is dependent a full time student over age 19? ☐Yes ☐No
If yes, please provide name of college/university ________________________________ Expected Graduation Date: ___ /___ /____

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal *

__________________________ Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____
Medicare Number (if applicable)

Note: Use an additional application if more than three dependents need coverage.

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage? ☐Yes ☐No

If yes, what type of coverage? ☐Medical ☐Dental

What is the effective date of the other coverage? ☐Medical: ____ /____ /______ ☐Dental: ____ /____ /______

What is the name of the other carrier? ________________________________

Are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage end? _____ /_____ /_________

Policyholder's name __________________________________ ID# ___________________________

Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

PREFERRED PROVIDER ORGANIZATION (PPO)
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

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 a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature ____ **Date** ____________________

Please return to P.O. Box 21146 Eagan, MN 55121
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1: Employer Group & Benefit Information

This section should be completed with your Group Administrator. Group Administrator's signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber's status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information

This section should be completed by the Subscriber.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 3: Reason for enrollment or change

Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information)

Please include information about all the people who you would like coverage for.

Use an additional application if more than three dependents need coverage.

If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.

Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

Section 6: Other coverage information (Required)

Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release

Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.