an excellus company
205 Park Club Lane, Buffalo, New York 14221

COMMERCIAL GROUP ENROLLMENT FORM

USE FOR UNIVERA 4-FRONT

DO NOT USE - MICROFILM ONLY

All Dates = mm/dd/yy

❑ Check if name change ❑ Check if new address

Please print clearly.

✓CHECK DESIRED ACTION	✓CHECK DESIRED COVERAGE - Select One Product Option	✓CHECK PERSON(S) COVERED
❑ **Add** Subscriber (AA) Date of Hire/Event ___/___/___ Coverage Eff Date ___/___/___ ❑ **Add** Dependent (AB) Date of Event ___/___/___ Coverage Eff Date ___/___/___ ❑ **Change** Coverage (AC) Coverage Eff Date ___/___/___	❑ PPO (PN) ❑ Traditional (TR) x☒ 4Front (EF) ❑ PPO/HSA (HF)	Self, Spouse & Child(ren) (A) — Medical ❑ Self & Child(ren) (B) ❑ Self & Spouse (C) ❑ Self (D) ❑

❑ **Transfer** to COBRA (AD) ❑ (S)ubscriber ❑ (M) Dependent ❑ (D)isabled Date of Event ___/___/___ ❑ **Cancel** Subscriber (S) ❑ **Cancel** Dependent (M) ❑ (M)edical Reason Code (see back)________ **Cancellation Date** ___/___/___	**SUBSCRIBER INFORMATION - Must be completed** Have you ever been a patient or member of Univera HealthCare? ❑ No ❑ Yes If yes, give name at that time____________ Social Security #|__|__|__| - |__|__| - |__|__|__|__| Sex: ❑M ❑F Birthdate:___/___/___ Last Name____________ First____________ Street____________ City____________ State______ Zip______ Day Phone:|__|__|__| - |__|__|__| - |__|__|__|__| E-Mail Address:____________

FAMILY MEMBER INFORMATION Complete for **ALL** eligible dependents **or** indicate Dependent Name and birthdate to be cancelled.

✓ Check Relationship and Indicate Member Name Below:	Member's Social Security #	Sex	Birhtdate (mm/dd/yy)
❑(S)pouse ❑(D)ependent ❑Student(T) ❑(H)andicapped ❑(F)oster Dependent Other____________ ***Last Name (if different)*** ***First Name***		❑M ❑F	___/___/___
❑(S)pouse ❑(D)ependent ❑Student(T) ❑(H)andicapped ❑(F)oster Dependent Other____________ ***Last Name (if different)*** ***First Name***		❑M ❑F	___/___/___
❑(S)pouse ❑(D)ependent ❑Student(T) ❑(H)andicapped ❑(F)oster Dependent Other____________ ***Last Name (if different)*** ***First Name***		❑M ❑F	___/___/___

Please answer the Other Coverage Information questions on the back

RELEASE - You must sign and date this form to be eligible for insurance.
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. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature____________________ **Date:** ______/______/______

EMPLOYER INFORMATION (Must be completed by Group Representative.)

Coverage	Group/Sub Grp #	Department #	Employer Name
			Employee Status ❑ (A)Active ❑(A)COBRA ❑(A)Cancellation ❑(R)Retired

Group Rep Signature	Date

APP-135 (07/04) *Return to Univera Healthcare* FORM P