If you wish to enroll in the District's Health Insurance Plan, or make changes to your current plan, please complete the **HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION**

Items 1-13
Item 1) Employer Name**- SCASD**

Items 2-12) Complete all items

Item-13) Check Type of Coverage**- Circle QHDHP or PPO**. Also check the box that indicates the type of coverage you are electing for **Medical and Drug only**- (Employee, Spouse/Domestic partner, Parent /child, Parent/children or Family).

Item 14) You do not need to complete.

Items 15-18
Include only family members that you wish to enroll on the health insurance plan. Make sure you include all social security numbers and dates of birth and gender. You do not need to provide Physician of Record or the POR number.

Item 15) Complete with your information.

Item 16) If adding your spouse/domestic partner you **must** also complete the **"Employer Information Form For Spouse/Domestic Partner".**

Items 17-18) Complete with your dependent's information.

Item 19) If you checked 'Yes" to other insurance, you must complete this item **(this includes Medicare).**

Item 21) Sign and date the form.

HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

HIGHMARK.

P.O. Box 890172
Camp Hill, PA 17089

EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name

Reason for Application ☐ New Hire ☐ Rehire ☐ Enrollment ☐ Act 4 ☐ Other: ☐ COBRA

2) Employee First Name / Middle Initial / Last Name

3) Street Address | 4) City | 5) State | 6) Zip

7) Social Security Number | 8) Effective Date of Coverage Month / Day / Year | 9) Employee Status ☐ Active ☐ Retired (Date) ☐ Hourly ☐ Salary

10) Employee Phone #—Home ( ) | 11) Employee Phone #—Work ( ) | 12) Employee Hire Date Month / Day / Year

13) Check Type of Coverage **MEDICAL**

Employee Only	☐
Insured & Spouse/Domestic Partner	☐
Family	☐
Parent & Child	☐
Parent & Children	☐

QHDHP or PPO
Please circle one

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo / Dy / Yr	Sex F/M	Check If: Student Benefits Apply	Disabled	Act 4
15) Self			☐ Yes ☐ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Are you an Established Patient? ☐ Yes ☐ No				
16) ☐ Spouse ☐ Dom. Part.*			☐ Yes ☐ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Spouse/DP an Established Patient? ☐ Yes ☐ No				
17) ☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐ Yes ☐ No				
18) ☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐ Yes ☐ No				

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

19) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status: ☐ Active ☐ Retired (Date) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

To the best of my knowledge and belief, the information provided on this application is true and correct. 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 subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) _____
Authorized Employer Signature — Date

21) _____
Employee Signature — Date

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association

MARGINAL WORDS