

HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION



Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

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

1) Employer Name			Reason for Application ☐ New Hire ☐ Rehire ☐ COBRA ☐ Act 4 ☐ Other:		13) Check Type of Coverage <table style="width:100%; text-align: center;"> <tr> <th>MEDICAL</th> <th>DENTAL</th> <th>VISION</th> <th>DRUG</th> <th>PRODUCT NAME</th> </tr> <tr> <td>Employee Only</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Insured & Spouse/Domestic Partner</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Family</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Parent & Child</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Parent & Children</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> </table>					MEDICAL	DENTAL	VISION	DRUG	PRODUCT NAME	Employee Only	☐	☐	☐	☐	Insured & Spouse/Domestic Partner	☐	☐	☐	☐	Family	☐	☐	☐	☐	Parent & Child	☐	☐	☐	☐	Parent & Children	☐	☐	☐	☐
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Parent & Children	☐	☐	☐	☐																																			
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		14) To be completed by Account Administrator only <table style="width:100%;"> <tr> <td>Group Number</td> <td>Report Code Qualifier</td> <td>Report Code Value</td> </tr> </table>		Group Number	Report Code Qualifier	Report Code Value																													
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Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)						Do you have other insurance? ☐ Yes ☐ No If YES, then complete #19	Birth Date			Sex F/M	Check If		
							Mo	Dy	Yr		Student Benefits Apply	Disabled	Act 4
15) Self	First Name / Middle Initial / Last Name					Social Security Number							
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.*	First Name / Middle Initial / Last Name					Social Security Number							
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*	First Name / Middle Initial / Last Name					Social Security Number							
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*	First Name / Middle Initial / Last Name					Social Security Number							
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: <table style="width:100%; text-align: center;"> <tr> <th>Name of Member</th> <th>Health Insurance Claim Number</th> <th>Part A Effective Date (Mo-Day-Yr)</th> <th>Part B Effective Date (Mo-Day-Yr)</th> <th>Part D Effective Date (Mo-Day-Yr)</th> </tr> <tr> <td>Last First</td> <td></td> <td>/ /</td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>/ /</td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>/ /</td> <td>/ /</td> <td>/ /</td> </tr> </table> 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	Name of Member	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)	Last First		/ /	/ /	/ /	_____	_____	/ /	/ /	/ /	_____	_____	/ /	/ /	/ /
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Last First		/ /	/ /	/ /																	
_____	_____	/ /	/ /	/ /																	
_____	_____	/ /	/ /	/ /																	

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

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