



Highmark Inc. d/b/a
Highmark Blue Cross
Blue Shield

HM Health Insurance Company d/b/a
Highmark Health Insurance
Company

Highmark Care
Benefits, Inc.

Highmark Coverage
Advantage Inc.

ENROLLMENT/WAIVER FORM

SECTION 1: EMPLOYEE/CONTRACT HOLDER INFORMATION

(Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name			Group Number
First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)	
Address			Email Address	
City	State	Zip	County	Home/Cell Phone
Marital Status (Please check one): ☐ Single/Widowed ☐ Married ☐ Divorced		Special Enrollment Type (if applicable) ☐ Rehired Employee ☐ COBRA Continuant Start Date _____ ☐ HIPAA Life Event (Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)		
Full-Time Hire (or Rehire) Date (Month/Day/Year)	Hours Worked Per Week	Date of Birth (Month/Day/Year)	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer	

The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. Your answer to the following questions are completely voluntary. In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) no deny your application based on whether you choose to answer these questions.

Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No ☐ Other ☐ Prefer not to answer

If you selected "Yes" to the above question, please select one:

- | | | |
|---|--|---|
| ☐ Cuban | ☐ Mexican, Mexican American, or Chicano/a | ☐ Puerto Rican |
| ☐ Other Hispanic, Latino or Spanish origin | ☐ Other | ☐ Prefer not to answer |

If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:

- | | | |
|--|--|---|
| ☐ American Indian or Alaskan Native | ☐ Korean | ☐ Pacific Islander race not listed above |
| ☐ Asian Indian | ☐ Native Hawaiian | ☐ Race not listed above |
| ☐ Black or African American | ☐ Samoan | ☐ Other _____ |
| ☐ Chinese | ☐ Vietnamese | ☐ Prefer not to answer |
| ☐ Guamanian or Chamorro | ☐ White | |
| ☐ Japanese | ☐ Asian race not listed above | |

Issuer of Medical Coverage:

- ☐ Highmark Inc. d/b/a Highmark Blue Cross Blue Shield
- ☐ Highmark Coverage Advantage Inc.
- ☐ HM Health Insurance Company d/b/a Highmark Health Insurance Company
- ☐ Highmark Care Benefits, Inc.

Issuer of Dental Coverage:

- ☐ HM Health Insurance Company d/b/a Highmark Health Insurance Company

Issuer of Vision Coverage:

- ☐ HM Health Insurance Company d/b/a Highmark Health Insurance Company

Product Election(s):

- ☐ Medical Product Name: _____ ☐ Vision ☐ Dental

SECTION 2: DEPENDENT INFORMATION

(If enrolling more than four dependents, please attached a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? ☐ Spouse ☐ Domestic Partner [†]
Social Security Number (If no SS#, write N/A)	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer		Date of Birth (Month/Day/Year)

The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. Your answer to the following questions are completely voluntary. In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) no deny your application based on whether you choose to answer these questions.

Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No ☐ Other ☐ Prefer not to answer

If you selected "Yes" to the above question, please select one:

- | | | |
|---|--|---|
| ☐ Cuban | ☐ Mexican, Mexican American, or Chicano/a | ☐ Puerto Rican |
| ☐ Other Hispanic, Latino or Spanish origin | ☐ Other | ☐ Prefer not to answer |

If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:

- | | | |
|--|--|---|
| ☐ American Indian or Alaskan Native | ☐ Korean | ☐ Pacific Islander race not listed above |
| ☐ Asian Indian | ☐ Native Hawaiian | ☐ Race not listed above |
| ☐ Black or African American | ☐ Samoan | ☐ Other _____ |
| ☐ Chinese | ☐ Vietnamese | ☐ Prefer not to answer |
| ☐ Guamanian or Chamorro | ☐ White | |
| ☐ Japanese | ☐ Asian race not listed above | |

Product Election(s):

- ☐ Medical ☐ Vision ☐ Dental

Note: [†] If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT			
First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Adopted* ☐ Other*
Social Security Number (If no SS#, write N/A)	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer		Date of Birth (Month/Day/Year)
The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. Your answer to the following questions are completely voluntary. In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) no deny your application based on whether you choose to answer these questions.			
Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No ☐ Other ☐ Prefer not to answer			
If you selected "Yes" to the above question, please select one:			
☐ Cuban ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Other Hispanic, Latino or Spanish origin ☐ Other ☐ Prefer not to answer			
If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:			
☐ American Indian or Alaskan Native ☐ Korean ☐ Pacific Islander race not listed above ☐ Asian Indian ☐ Native Hawaiian ☐ Race not listed above ☐ Black or African American ☐ Samoan ☐ Other _____ ☐ Chinese ☐ Vietnamese ☐ Prefer not to answer ☐ Guamanian or Chamorro ☐ White ☐ Japanese ☐ Asian race not listed above			
Product Election(s): ☐ Medical ☐ Vision ☐ Dental			Dependent Status if Age 26 or Older ☐ Disabled ☐ Act 4**

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

DEPENDENT			
First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Adopted* ☐ Other*
Social Security Number (If no SS#, write N/A)	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer		Date of Birth (Month/Day/Year)
The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. Your answer to the following questions are completely voluntary. In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) no deny your application based on whether you choose to answer these questions.			
Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No ☐ Other ☐ Prefer not to answer			
If you selected "Yes" to the above question, please select one:			
☐ Cuban ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Other Hispanic, Latino or Spanish origin ☐ Other ☐ Prefer not to answer			
If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:			
☐ American Indian or Alaskan Native ☐ Korean ☐ Pacific Islander race not listed above ☐ Asian Indian ☐ Native Hawaiian ☐ Race not listed above ☐ Black or African American ☐ Samoan ☐ Other _____ ☐ Chinese ☐ Vietnamese ☐ Prefer not to answer ☐ Guamanian or Chamorro ☐ White ☐ Japanese ☐ Asian race not listed above			
Product Election(s): ☐ Medical ☐ Vision ☐ Dental			Dependent Status if Age 26 or Older ☐ Disabled ☐ Act 4**

DEPENDENT			
First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Stepchild ☐ Adopted* ☐ Other*
Social Security Number (If no SS#, write N/A)	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer		Date of Birth (Month/Day/Year)
The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. Your answer to the following questions are completely voluntary. In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) no deny your application based on whether you choose to answer these questions.			
Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No ☐ Other ☐ Prefer not to answer			
If you selected "Yes" to the above question, please select one:			
☐ Cuban ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Other Hispanic, Latino or Spanish origin ☐ Other ☐ Prefer not to answer			
If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:			
☐ American Indian or Alaskan Native ☐ Korean ☐ Pacific Islander race not listed above ☐ Asian Indian ☐ Native Hawaiian ☐ Race not listed above ☐ Black or African American ☐ Samoan ☐ Other _____ ☐ Chinese ☐ Vietnamese ☐ Prefer not to answer ☐ Guamanian or Chamorro ☐ White ☐ Japanese ☐ Asian race not listed above			
Product Election(s): ☐ Medical ☐ Vision ☐ Dental			Dependent Status if Age 26 or Older ☐ Disabled ☐ Act 4**

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

SECTION 3: WAIVER OF COVERAGE

(Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

☐ For myself

☐ For family members **ONLY**:

☐ For myself and **ALL** family members

☐ For the following family members:

REASON FOR DECLINING MEDICAL COVERAGE:

☐ I already have medical coverage.

☐ I do **not** have other medical coverage and do **not** want coverage at this time.

VISION

I HEREBY DECLINE VISION COVERAGE:

☐ For myself

☐ For family members **ONLY**

☐ For myself and **ALL** family members

☐ For the following family members:

REASON FOR DECLINING VISION COVERAGE

☐ I already have vision coverage

☐ I do **not** have other coverage and do **not** want coverage at this time.

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

☐ For myself

☐ For family members **ONLY**

☐ For myself and **ALL** family members

☐ For the following family members:

REASON FOR DECLINING DENTAL COVERAGE:

☐ I already have dental coverage

☐ I do **not** have other coverage and do **not** want coverage at this time.

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Employee/Contract Holder Signature (please hand sign if this is a paper request).

Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer, or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).

SECTION 4: OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status ☐ Active ☐ Retired Date of Retirement: _____

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Medicare Number	Effective Dates			Check (✓) Reason for Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
					☐	☐	☐	☐ Yes ☐ No
					☐	☐	☐	☐ Yes ☐ No
					☐	☐	☐	☐ Yes ☐ No

SECTION 5: IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

(All references below to "Highmark" refer to the Highmark company from which coverage is being requested.)

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark 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.

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 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 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 the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Employee/Contract Holder Signature (please hand sign if this is a paper request)

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and supporting documentation) to your Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders or dependents to an existing group, please send Enrollment/Waiver Forms to one of the following addresses:
Email: enrollmentandbilling@highmark.com

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

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Coverage Advantage, Highmark Health Insurance Company or Highmark Care Benefits, Inc.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkdotcom/pdfs/quality-assurance/CS204330_NCQAPreSale_BRO_BCBS_R2.pdf; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY:711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

توجہ: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועלעבל פאר אייך. רופט די נומער וואס איז אויף די פארקערטע זייט פון אייער ID קארטל (TTY:711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনার আইডি কার্ডের (TTY:711) পিছনে থাকা নম্বরে ফোন করুন।

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لنذوي صعوبات السمع والنطق: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ΠΡΟΣΟΧΗ: Σε περίπτωση που μιλάτε Ελληνικά, οι διαθέσιμες υπηρεσίες γλωσσικής βοήθειας σας παρέχονται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της ταυτότητας σας (TTY:711).

United Concordia[™] Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely:



Correct



Incorrect

For best results, print in capital letters and avoid contact with edge of box.

Example:

A	B	C
---	---	---

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

☒ **FFS—Indemnity, Active PPO, Passive PPO**

(Please specify)

- ☐ Concordia Access
- ☐ Concordia Choice
- ☐ Concordia Flex
- ☐ Concordia Preferred
- ☐ Concordia Select
- ☐ Other _____

☐ **DHMO** (Please specify)

- ☐ Concordia Plus
- ☐ Other _____

Provider Number (DHMO only)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. TYPE OF ACTIVITY

☒ **New Enrollment**

☐ **Cancel Coverage**

- ☐ Cancel All Coverage (Employee & All Dependents)
- ☐ Cancel Dependent(s) Only
(List dependents to be cancelled in Section D)
- ☐ Cancel Spouse Only
(List spouse to be cancelled in Section D)

☐ **Change (Include Group Number in Section B)**

- ☐ Add Dependent
(e.g., spouse, domestic partner, child, etc.)
- ☐ Change Address
- ☐ Reinstate Coverage
- ☐ Change Group Number
- ☐ Change Provider
- ☐ Change Name
- ☐ To COBRA Group
- ☐ Other _____

Effective Date (mm/dd/yyyy)

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SECTION B: EMPLOYER USE ONLY

Employer Name

Wyoming Valley West School District

Group Number (9 digits)

8	3	6	5	3	0	4	4	0
---	---	---	---	---	---	---	---	---

UCCI Payroll Location

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth (mm/dd/yyyy)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Original Employment Date (mm/dd/yyyy)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

M.I.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Home Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ZIP Code

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

Spouse/Domestic Partner

Identification Number (Social Security Number)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth (mm/dd/yyyy)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Number (DHMO only)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

#1

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

M.I.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Dependent

Identification Number (Social Security Number)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth (mm/dd/yyyy)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Provider Number (DHMO only)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

#2

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

M.I.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--



Dependent		Identification Number (Social Security Number)		Date of Birth (mm/dd/yyyy)		Gender		Provider Number (DHMO only)	
#6									
First Name				M.I.		Last Name			

Program Availability

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

State Mandated Provisions

- | | |
|--|---|
| <p>CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</p> <p>FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.</p> <p>AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.</p> <p>KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.</p> <p>LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p> | <p>NY: 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 five thousand dollars and the stated value of the claim for each such violation.</p> <p>OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.</p> <p>OR: Contestability is limited to two years as stated in the Group Policy.</p> <p>TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.</p> <p>UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.</p> <p>VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.</p> |
|--|---|

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- | | |
|---|--|
| <ul style="list-style-type: none"> • United Concordia Dental Corporation of Alabama—AL • United Concordia Dental Plans, Inc.—DC, MD, NJ • United Concordia Dental Plans of California, Inc.—CA • United Concordia Dental Plans of Florida, Inc.—FL • United Concordia Dental Plans of Kentucky, Inc.—KY • United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH • United Concordia Dental Plans of Pennsylvania, Inc.—PA | <ul style="list-style-type: none"> • United Concordia Dental Plans of Texas, Inc.—TX • United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY • United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA • United Concordia Insurance Company of New York—NY |
|---|--|

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Davis Vision Enrollment Application

Employee Information (Please Print)



Employer Name/Group Number		Reason For Application:		☐ Addition ☐ Reinstatement ☐ Termination	
☐ Change ☐ COBRA ☐ Waive Coverage					
Employee (Member) First Name / Middle Initial / Last Name					
Mailing Address		City		State	Zip code
Employee (Member) Identification Number		Effective Date		Employee Status	
		Month	Day	Year	☐ Active ☐ Hourly ☐ Salary
				☐ Retired (Date)	
Employee Phone Number		Employee Hire Date			
		Month	Day	Year	

Check Type of Coverage:

☐ Employee Only

☐ Employee and Spouse or Domestic Partner

☐ Family

☐ Employee & Child

☐ Employee & Children

To be completed by Account Administrator or Human Resources representative only:

Group Number

Payroll Code

Subgroup Code

Plan Code

Please indicate the change(s) that you need to make to your record:

☐ Change of Name	☐ Change Birthdate	☐ Change Report Code	☐ Change in Group Number	☐ Change Enrollment Status to:	☐ Employee/Children	☐ Employee and Child
☐ Change of Address	☐ Change Effective Date	Existing _____	Existing _____	☐ Employee Only	☐ Employee and Spouse / Domestic Partner	☐ Family
☐ Change of Phone	New _____	New _____	New _____			

Complete If Applicable	First Name / Middle Initial / Last Name	Social Security Number	Change	Effective Date of Change			Sex	Check If	Birth Date*		
				MM	DD	YY			F/M	Student Over 19	MM
☐ Self			☐ Add ☐ Term								
☐ Spouse			☐ Add ☐ Term								
☐ Dom. Part			☐ Add ☐ Term								
☐ Child			☐ Add ☐ Term								
☐ Other			☐ Add ☐ Term								
☐ Child			☐ Add ☐ Term								
☐ Other			☐ Add ☐ Term								
☐ Child			☐ Add ☐ Term								
☐ Other			☐ Add ☐ Term								
☐ Child			☐ Add ☐ Term								
☐ Other			☐ Add ☐ Term								
☐ Child			☐ Add ☐ Term								
☐ Other			☐ Add ☐ Term								

"I certify that this enrollment information is true and correct."

Member/Employee Signature

Date

* Required for all Employee/dependents