HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign.

HIGHMARK. Blue Cross Blue Shield

Fifth Avenue Place
120 Fifth Avenue Suite 2311
Pittsburgh, PA 15222-3099

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYEE INFORMATION

1) Employer Name			Reason for Application: ☐ New Hire ☐ Rehire ☐ Enrollment ☐ COBRA ☐ Other:		
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	DENTAL	VISION	DRUG	PRODUCT NAME
Employee Only	☐	☐	☐	☐	☐
Insured & Spouse/Domestic Partner	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Parent & Child	☐	☐	☐	☐	☐
Parent & Children	☐	☐	☐	☐	☐

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 19 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	Complete Where Applicable	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo	Birth Date Dy	Birth Date Yr	Sex F/M	Check If Student Over 19	Check If Dis-abled
15)	Self			☐ Yes ☐ No If YES, then complete #20						
16)	☐ Spouse ☐ Dom. Part.*			☐ Yes ☐ No If YES, then complete #20						
17)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						
18)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						
19)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						

***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**

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

21) ____

Authorized Employer Signature Date

22) ____

Employee Signature Date

HBCBS COPY

HIGHMARK® Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER CHANGE FORM

Membership Department
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

Employer Name		Employer Telephone Number ( )		Association Name (if applicable)
Group Number	Employee (Last)	(First)	(M.I.)	Member Identification Number

Please check the changes that you need to make to your member records:

- ☐ Change PCP
- ☐ Change of Name
- ☐ Change of Address
- ☐ Change of Phone
- ☐ Change Birthdate
- ☐ Change Hire Date ______
- ☐ Change Report Code
  - Existing: ______
  - New: ______
- ☐ Change in Group Number
  - Existing: ______
  - New: ______
- ☐ Change Identification Number
- ☐ Change Effective Date
- ☐ Add Spouse/Dependent(s)
- ☐ Change Spouse/Dependent Status
- ☐ Delete Spouse/Dependent(s)
- ☐ Change Contract type to (check new contract type)
  - ☐ POS ☐ Comp. ☐ MM ☐ Vision
  - ☐ PPO ☐ BC ☐ Dental ☐ Product Name: ______
  - ☐ HMO ☐ BS ☐ Drug
- ☐ Change Enrollment Status to
  - ☐ Single ☐ Parent/Children
  - ☐ Insured & Spouse/Domestic Partner
  - ☐ Parent/Child ☐ Family

Effective Date of Change	Please give a brief description of the changes to be made.

COMPLETE **ONLY** THE SECTIONS THAT APPLY TO **CHANGES** IN MEMBER RECORDS.

Street Address	City	State	Zip Code	Home Phone ( )	Work Phone ( )

	Employee/Contract Holder	Spouse/Domestic Partner	Dependent	Dependent	Dependent
Type of Change	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare
Previous Member Identification Number	— —	— —	— —	— —	— —
Current Member Identification Number	— —	— —	— —	— —	— —
Previous Last Name	Last	Last	Last	Last	Last
Current Last Name	Last	Last	Last	Last	Last
First Name Middle Initial	First M.I.	First M.I.	First M.I.	First M.I.	First M.I.
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Member Status	(20) Employee	(01) ☐ Spouse (29) ☐ Domestic Partner	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild
Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Primary Care Physician Name					
Primary Care Physician Number					
Existing Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marriage Date	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year

Please check one if applicable (If additional space is required, attach a separate sheet). If you ☐, your spouse/domestic partner ☐, or dependent(s) ☐, are enrolled in another Program or Medicare, please give the following information:

Group No: ______ Name of Insurance Carrier: ______

Name of Insured: ______ Identification Number: ______

IMPORTANT: PLEASE READ AND SIGN BELOW: *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.*

Employee's Signature and Date ______ Authorization Employer's Signature and Date ______

WHITE AND CANARY: HBCBS • PINK: EMPLOYER • GOLDENROD: EMPLOYEE