HOW TO COMPLETE YOUR HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

FOLLOWING ARE INSTRUCTIONS FOR COMPLETING THE HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION. ALL INFORMATION MUST BE COMPLETED AS INDICATED.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

1) Employer Name and Reason for Application

2) Employee First Name, Middle Initial, Last Name.

3) Employee Street Address

4) City

5) State

6) Zip Code

7) Employee Social Security Number

8) Effective Date of Coverage

9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.

10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.

11) Employee Work Phone Number (including area code)

12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

14) To be completed by Account/Administrator only

Items **15** through **18** ask for important information about yourself and each eligible member of your family (**15** yourself, **16** your spouse/ domestic partner, **17-18** your dependents). Please complete all requested information. If relationship is "other", please indicate the dependent's relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **Social Security Number** — Please include the Social Security Number of each person.
- **Do you have other insurance?** — If you or a family member have other medical insurance including Medicare, respond "yes". If not, you must respond "No".
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over Maximum Regular Dependent Age, Disabled and/or Act 4 dependent** If your dependent is over the Maximum Regular Dependent Age and is a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent's name.

Physician of Record (POR) Information — A Physician of Record is the physician selected by the member, who provides routine care and coordinates other specialized care. Please note that choosing a POR does not impact your benefits or claims payment in any way. Choosing a POR simply helps us to better serve you by connecting you to the practice where most of your health care is received.

a) **Full Name of Physician of Record (POR) Group Practice** — Indicate the name of the POR Group Practice selected from the Online Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different POR.

b) **Physician of Record (POR) Number from Provider Directory** — Please indicate the corresponding number for the physician practice you or your dependent chose as a POR from the Online Provider Directory, Practice Information tab.

c) **Are you an existing Patient of this POR?** — Please check "Yes" or "No" to indicate if you are currently a patient of the POR you chose for yourself or your dependents.

For online provider lookup, go to www.highmarkbcbs.com and search under the "Find a Doctor or Rx" tab. If you need assistance with choosing a POR, please call Member Service at 1-800-241-5704.

Disclaimer: Please note that a provider number may not be available for providers that are located outside of the local servicing area. In this case, a POR cannot be chosen.

19) Needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested. Refer to your Medicare card to complete the Medicare Information section.

20) Should be completed by your Account Administrator.

21) You must sign and date the form where indicated.

Once the form is completed, retain the last copy for your records.

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 ❑ 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**	**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 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	Dis-abled	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

MARGINAL WORDS