



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 335193
Pittsburgh, PA 15253-5193

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

1) Employer Name	Reason for Application <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Other		<input type="checkbox"/> Enrollment <input type="checkbox"/> 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 <input type="checkbox"/> Active <input type="checkbox"/> Retired (Date)	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	
10) Employee Phone #—Home ()	11) Employee Phone #—Work ()	12) Employee Hire Date Month / Day / Year		
13) Check Type of Coverage		MEDICAL	DENTAL	VISION
Employee Only		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured & Spouse/Domestic Partner		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Child		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Children		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) To be completed by Account Administrator only		Report Code Qualifier	Report Code Value	
Group Number				

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

15) Self	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 Dis-abled Act 4
a) Full Name of Physician of Record (POR) Group Practice <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24			
b) POR Number from Provider Directory						
c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No						
a) Full Name of Physician of Record (POR) Group Practice <input type="checkbox"/> Child <input type="checkbox"/> Other*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24			
b) POR Number from Provider Directory						
c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No						
a) Full Name of Physician of Record (POR) Group Practice <input type="checkbox"/> Child <input type="checkbox"/> Other*	First Name / Middle Initial / Last Name	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #24			
b) POR Number from Provider Directory						
c) Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ Effective Date: _____ Group No: _____ Name of Policy Holder: _____ Policy Number: _____ Relationship to Highmark Policy Holder: _____ Policy Holder Date of Birth: _____ Policy Holder Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired (Date) _____	MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits: Name of Member: _____ First Last First Last Why are you eligible for Medicare? <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Do you have a Medicare Supplement or other coverage that complements Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	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): _____
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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) _____ Date _____
Authorized Employer Signature _____ Date _____
Employee Signature _____ Date _____
21) _____
Health Plan Copy