

INSTRUCTIONS FOR COMPLETING YOUR ENROLLMENT/WAIVER APPLICATION AND CHANGE FORM

The descriptions below should be used when completing applicable sections of your Enrollment/Waiver Application and Change Form.

In the top right hand corner please list the Product Name under which you are enrolling. Then indicate the **Type of Coverage** that you have selected for you and your eligible dependents (e.g. employee only, two person, etc.)

Employee/Applicant Information (Section I): This section must always be completed even if your coverage has not changed.

- **Effective Date of Coverage** – The effective date of new coverage or, in the event of a change in existing coverage, the effective date of the change.
- **Group Number** – To be completed only if the reason for the application is COBRA, dependent status changes or addition of an Act 4 eligible dependent (i.e. qualified dependent up to Age 30.)

Covered Dependent Enrollment/Change Information (Section II): This section requires important information about yourself and each eligible member of your family. If relationship is “Domestic Partner” or “Other,” please indicate the dependent’s relationship to the employee using the codes provided on the application.

Do you have other insurance? – If you or your family members have other medical insurance, including Medicare, respond “yes.” If not, you **must** respond “no.”

- **Check If Disabled, Student over 19 or Act 4** (dependents up to age 30) – If your dependent is a full time student (age 19 or over), an eligible disabled dependent (any age) or entitled to enroll for coverage under Act 4 (qualified dependent up to age 30), please check the appropriate column by that dependent’s name. Act 4 eligibility is at the discretion of the employer.
- **Dependent Changes** – If adding or terminating a dependent, check the appropriate box. Please be sure to include the date of the event leading to this change.
- **Other Changes** – This column should be used to indicate changes in either your coverage and/or that of your dependents. Please check the appropriate box and include the date of the event leading to this change.
- **Cancel/COBRA Reasons** – When you and/or your dependents enroll in COBRA, the reason must be indicated.
- **Additional Comments** – If additional space is needed to describe any changes, this can be documented in Section VIII.

Waiver Information (Section III): This section must be signed and indicate the reason why you are waiving group coverage for yourself and/or your dependents.

About Your Other Group or Non-Group Health Insurance Coverage and Medicare (Section IV): If you checked “yes” to the question “Do you have other insurance?” in Section II, then you must complete this section by identifying all other coverages each enrollee has.

Authorized Signature’s (Required) (Section V): This section must be completed in all cases. Your signature authorizes the enrollment of you and your dependents under the coverage selected. Both your signature and your employer’s signatures are required.

Medical History Information (Section VI): This section is to be completed for you and all eligible dependents you elect to enroll in this group coverage. This includes all dependents that you listed in Section II.

Explanation Section (Section VII): This section is to be used to provide detailed medical history information. Please **DO NOT INCLUDE** any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk.

Other Information (Section VIII): This section should be used to provide additional information and comments relating to your enrollment request.

Employee Signature (Section IX): Your signature is required in all cases when enrolling in group coverage. By signing this form, you are ensuring that all information provided in this application, including Sections VI-VIII is complete, true and accurate.

Reminder: In order for your request to be processed, you must complete each of the Sections indicated below:

Initial Enrollment: Complete Sections I, II, IV, V, VI, VII, VIII and IX

Waiving Coverage: Complete Sections I and III. Employer Signature Required on Section V.

Changing Existing Coverage: Complete Sections I, II, IV and V

Changing Existing Coverage and Adding Dependent(s): Complete Sections I, II, IV and V



An Independent Licensee of the Blue Cross and Blue Shield Association

Enrollment/Waiver Application and Change Form

**Complete this application in its entirety in blue or black ink.
Do not use pencil or highlighter.**

Product Name: _____

Check Type of Coverage	MEDICAL	VISION	DENTAL
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two Person*	<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"/>

*Employee and Spouse/Domestic Partner only

I. Employee/Applicant Information

Effective Date of Coverage / /		Employer Name			Group Number		Reason for Application	
Employee Name - <i>First</i>		<i>Middle Initial</i>		<i>Last</i>		Phone Number ()		<input type="checkbox"/> New Enrollee
Street Address		City		County		State		Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled		Date of Hire / /		Hours worked per week		<input type="checkbox"/> COBRA Start Date: _____ End Date: _____
Social Security Number		Job Title		Email Address (optional)				<input type="checkbox"/> Changes <input type="checkbox"/> Act 4 <input type="checkbox"/> Qualifying Event

II. Covered Dependent Enrollment/Change Information

Dependent Relationship. Complete as applicable	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page	Birth Date			Sex F/M	Check If			Enrollment Changes		
				Mo	Dy	Yr		Dis-abled	Student Over 19	Act 4	Dependent Changes	Other Changes	Cancel/COBRA Reasons
<input type="checkbox"/> Self			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page								<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Deceased <input type="checkbox"/> Left Employment <input type="checkbox"/> Involuntary Lay-Off <input type="checkbox"/> Other Coverage	
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page								<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page								<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page								<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page								<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this application if relationship is "Other."

III. Waiver Information

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S)

For: Medical Vision Dental

I hereby decline coverage:

For myself For myself and ALL family members For family members ONLY

For the following person(s): _____

Reason for declining coverage:

Insured under own contract with: _____

Insured under spouse's contract with the following insurance carrier: _____

Do not have health coverage under any plan

Other _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. 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 qualifying event occurs before coverage will be offered.

Signature _____

Date _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your 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, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

EMPLOYER SIGNATURE REQUIRED ON NEXT PAGE

IV. About Your Other Group or Non-Group Health Insurance Coverage and Medicare

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder	
Policy Holder Date of Birth / /	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired - List Date of Retirement: / /		Relationship to Policyholder	Policy Number

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

Self - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Spouse - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Dependent - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Health Insurance Claim Number	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	

V. IMPORTANT: Authorized Signatures (required)

I understand that this form enrolls those eligible persons listed above in the Products 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.

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.

Authorized Employer Signature Date

Print Company Name

Employee Signature Date

Print Employee's Name



Highmark
P.O. Box 890172
Camp Hill, PA 17089-0172

or

Fax to: 888-567-5685

**Office Use Only.
Do not write in
the spaces below.**

Group Number

Report Code Qualifier

Report Code Value

VI. Medical History Information

Employee Name - *First*

Last

Social Security Number

Phone Numbers - *Home*

()

Work

()

Cell

()

Best number to reach you : Home Work Cell

Best time to call:

Please answer each question below as completely as possible. **NOTE:** Medical information disclosed in this section will not be used to determine the eligibility of you and/or your dependents to enroll in the coverage requested. **If you or any of your dependents have EVER had any of the conditions listed below, please indicate by marking an "X" in each appropriate box.** Then, in the **Explanation** section on the next page, list the patient's name, diagnosis, treatment(s) and treatment date(s), surgeries and surgery date(s), and the prognosis for each condition marked.

*If additional space is needed, use Other Information (section VIII) Attach additional sheets if necessary.

Your Height	ft.	in.	Your weight	lbs.	Spouse's Height	ft.	in.	Spouse's Weight	lbs.
Dependent Name*					Height		Weight		
					ft.		in.		lbs.
					ft.		in.		lbs.
					ft.		in.		lbs.

1. **CANCERS**

Presence or History of Cancer Yes No

If yes: Type/Location of cancer: _____

Currently treated: Yes No

If yes: Are IV's or infusions required

Yes No

If yes: Are oral medications required?

Yes No

Hemophilia

High Blood Pressure

High Cholesterol

Rheumatic Fever

Rheumatic Heart Disease

TIA < or > 3 months _____

Stroke < or > 1 year _____

Irregular or rapid heart beat

Heart Valve Replacement

Mitral

Operated or Asymptomatic

Aortic

Operated or Asymptomatic

6. **IMMUNE**

AIDS

HIV

Any Immune Suppressed Illness

Mononucleosis/Epstein Barr Virus

Chronic Fatigue Syndrome

Injections

IM: Yes No

IV: Yes No

Systemic Lupus < or > 1 year _____

Colostomy, Still Open Closed

Crohn's Disease: Operated

Diabetes

Type I or Juvenile:

Insulin Injections Insulin Pump

Other _____

Type II

Diet Controlled

Oral Medications

Insulin Injections

Insulin Pump

Hepatitis

A: present recovered

B: acute chronic recovered

C: acute chronic recovered

Pancreatitis

Acute Operated

Chronic

Ulcerative Colitis

Operated

Thyroid Disorders

Hypothyroid

Hyperthyroid

Goiter

Operated

Stomach Ulcer

Operated

GERD (Gastric Esophageal Reflux Disorder)

2. **TUMORS**

Presence or History of non-cancerous

Tumors: Yes No

If yes: Type of Tumor _____

Location of Tumor _____

Operated: Yes No

4. **LUNG**

Apnea

Use C-PAP Operated Newborn

Asthma

Allergy

Cystic Fibrosis

Emphysema

Tuberculosis

Current History of

Positive skin test only

COPD

5. **HEART/LUNG TREATMENTS**

Angioplasty

Single More than one

Coronary Artery Bypass

Single More than one

Cardiac Catheterization

Pace Maker or Defibrillator Implantation

3. **HEART**

Anemia Type _____

Aneurysm Type _____

Location _____

Blood Clot Type/Location _____

Coronary Artery Disease

Operated: Yes No

Congenital Heart Disease

Type/Location _____

Congestive Heart Failure

< or > 6 months _____

Heart Attack

Single Multiple

7. **RENAL**

Polycystic Kidney Disease: Operated

Renal Failure

Acute, Dialysis: Yes No

If yes: Hemodialysis or

Peritoneal Dialysis

If no: < or > 1 year _____

Chronic, Dialysis: Yes No

If yes: Hemodialysis or

Peritoneal Dialysis

Kidney Stones, Operated or Passed

8. **DIGESTIVE/INTESTINAL/ENDOCRINE**

Cirrhosis of Liver

Employee Name: _____

VI. Medical History Information, continued

9. NEUROLOGICAL/PSYCHOLOGICAL

- Alzheimer's
- Amyotrophic Lateral Sclerosis – Lou Gehrig's Disease
- ADD or ADHD
- Bipolar Disorder
- Schizophrenia
- Psychotic Disorder
- Anxiety
- Anorexia or Bulimia
 - Active
 - Recovered
- Attempted Suicide
- Cerebral Palsy
 - Currently under age 5?
 - Currently age 5 or over?
 - Functionally Dependent
 - Functionally Independent
- Depression
- Drug Abuse
 - Current
 - Past
- Alcohol Abuse
 - Current
 - Past
- Epilepsy
 - Febrile
 - Primary Generalized
- Multiple Sclerosis
 - Neurological Disability
 - Wheelchair Bound? Yes No
 - Asymptomatic/Remission
 - Wheelchair Bound? Yes No
- Paralysis
 - Quadriplegic
 - Paraplegic
 - Hemiplegic
 - Bells Palsy
 - Other
- Parkinson's
 - Controlled
 - Other _____
- Spina Bifida:
 - Operated
 - Non-Operated
 - Cervical (neck)

10. MUSCULAR/SKELETAL

- Fibromyalgia
- Amputation
 - finger or toe
 - Non-Disease
 - Disease
 - One hand or arm
 - Non-Disease
 - Disease
 - leg or foot
 - Non-Disease
 - Disease
 - more than one amputation
 - Non-Disease
 - Disease
- Arthritis
 - Psoriatic
 - Rheumatoid
 - Osteo
 - use no medications
 - use OTC medications
 - use prescription medications
- Degenerative Disc/Herniated Disc
 - Location _____
 - Operated
 - Symptomatic
 - Asymptomatic
 - Unoperated
 - Current History
 - Past History
- Fractures
 - Arm
 - Operated
 - Unoperated
 - Leg
 - Operated
 - Unoperated
 - Spine
 - Operated
 - Unoperated
 - Fingers or Toes
 - Operated
 - Unoperated
 - Skull
 - Operated
 - Unoperated
- Other _____
 - Operated
 - Unoperated
- Joint Replacement
 - Surgery Completed
 - Surgery Anticipated
- Muscular Dystrophy
- Osteoporosis

11. REPRODUCTIVE

- BPH (enlarged prostate)
 - Operated
 - Unoperated
- Infertility
- Pregnant
 - Single Fetus
 - Multiple Fetuses
 - Past Pregnancy Complications (i.e. Gestational Diabetes, Miscarriage, Premature Birth) _____
- Sexually Transmitted Disease(s)
 - Present
 - History of
- Endometriosis
 - Operated
 - Unoperated
- Polycystic Ovary
 - Operated
 - Unoperated
- Abnormal Pap
 - Current
 - History of
- Breast Conditions
 - Implants
 - Operated
 - Unoperated
 - Reduction
 - Operated
 - Unoperated
 - Reconstruction
 - Operated
 - Unoperated
- Fibrocystic Breast Disease
- Other Reproductive _____

12. SKIN/INTEGUMENTARY

- Psoriasis
- Acne
- Cyst
 - Operated
 - Unoperated
- Burns
 - 1st Degree
 - 2nd Degree
 - 3rd Degree
 - Under Treatment
 - Treatment concluded
- Other _____

13. Are any types of tobacco used? Yes No

14. Have you ever had or been advised to have an organ or bone marrow transplant?

Yes No

If yes, please explain _____

If yes, Pending or Completed

15. Any other medical conditions not listed above that have ever been diagnosed or treated by a health care provider?

Yes No

16. Have you been advised to have surgery which has not been preformed yet? If yes, please explain _____

17. Do you take any over the counter (OTC) medications? If yes, please list OTC medication and the reason for the OTC medication. _____

18. Have you ever been covered by Worker's Compensation? If yes, is Worker's Compensation case still open? _____

Dates covered _____

19. Have you ever been covered by Disability? If yes, is case still open? _____

Dates covered _____

20. In the last five years have you been treated (including medication) for, diagnosed with, or sought treatment from a member of the medical profession for: Macular degeneration, retinitis, pigmentosa, retinopathy? Yes No

VII. Explanation Section

When completing the application, please **DO NOT INCLUDE** any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk. Provide an explanation for each box marked in questions 1 - 12 and for each box marked "Yes" in questions 14 - 20 from the previous page. Any prescription medications that are **not** in response to the questions above - please list prescription medication and the reason for the medication. If additional space is needed, use the **Other Information** section below. Attach additional sheets if necessary.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Treatment Dates		# of times hospitalized for this condition?	Date of most recent inpatient stay		Medications
					From	To		From	To	
List prescription medications not in response to the questions listed above										

VIII. Other Information (continue on a separate sheet of paper if necessary)

IX. IMPORTANT: Employee/Applicant Signature (required)

I understand that this form enrolls those eligible persons listed above in the Products 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. I further acknowledge and agree that Highmark may disclose

enrollment, disenrollment summary health and/or premium billing information requested by the POR (Producer of Record) for purposes of inputting, updating and/or reviewing the same for the above identified business.

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.

Employee Signature

Date

Print Employee Name