

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	

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



For New Business:

Highmark
Small Group Sales
120 Fifth Avenue Suite P2504
Pittsburgh, PA 15222

For Changes:

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

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

Group Number
Report Code Qualifier
Report Code Value

MEDICAL UNDERWRITING APPLICATION

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

EMPLOYEE APPLICATION INFORMATION

Social Security Number (use boxes below)										Employer Name										Effective Date					Phone Number(s)														
Employee's Last Name (Please Use the Boxes)										First Name										MI	Home (____) _____					Work (____) _____					Cell (____) _____								
Street Address										City					State					Zip					County					Best number to reach you <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell					Best time to call <input type="checkbox"/> AM <input type="checkbox"/> PM				

COVERED DEPENDENT INFORMATION

Relationship	First Name	Last Name	Height - ft.	in.	Weight
<input type="checkbox"/> Self					
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.					
<input type="checkbox"/> Child <input type="checkbox"/> Other					
<input type="checkbox"/> Child <input type="checkbox"/> Other					
<input type="checkbox"/> Child <input type="checkbox"/> Other					

MEDICAL HISTORY INFORMATION

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 any of the conditions listed below, please check all numbers and circle the specific condition(s) that apply.**

Then, in the **Explanation** section on the next page, please give details for all diagnosis circled in questions 1 -27. If additional space is needed, use Other Information. Attach additional sheets if necessary.

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> 1. Cancer, Leukemia, Tumor or Cyst <input type="checkbox"/> 2. Heart Surgery (Angioplasty, Stent or Bypass), Heart Disease, Implanted Pace Maker or Defibrillator, Irregular Heartbeat, Heart Murmur, Heart Regurgitation, Chest Pain, Congestive Heart Failure or Mitral Valve Prolapse <input type="checkbox"/> 3. Vasculitis or Peripheral Vascular Disease <input type="checkbox"/> 4. High Blood Pressure, and/or High Cholesterol <input type="checkbox"/> 5. Emphysema, COPD, Cystic Fibrosis, Asthma or Allergies <input type="checkbox"/> 6. Sleep Apnea, or Disease of the Throat, Ears, Nose, Sinuses or Eyes (except glasses) <input type="checkbox"/> 7. Ulcerative Colitis, Crohn's, Diverticulitis, Stomach Ulcers, Acid Reflux, GERD, Hernia, Gallbladder or Rectal Disorders <input type="checkbox"/> 8. Diabetes Type I or II <input type="checkbox"/> 9. Hypothyroid, Hyperthyroid, Goiter, Pituitary, Pancreas or Glandular Disorders or Disorders requiring Growth Hormones <input type="checkbox"/> 10. Hepatitis (please circle type): A, B, C, or Autoimmune Hepatitis <input type="checkbox"/> 11. Bladder, Kidney, Prostate, Testicular, Uterine, Kidney Failure or Dialysis, Abnormal PAP in the last 5 years or Breast Condition <input type="checkbox"/> 12. Any female to be covered currently Pregnant? Due Date _____. If yes, how many fetuses (single, twins, triplets, etc.). If pregnant, please give details including any complications | <ul style="list-style-type: none"> <input type="checkbox"/> 13. Arthritis (Osteo, Rheumatoid or Other), Joint Replacement, Joint Pain, Lupus, Fibromyalgia, Fractures or Limb Loss <input type="checkbox"/> 14. Neck or Back Pain, Disorders of the Spine or Disc Herniation/Bulging <input type="checkbox"/> 15. Head or Spinal Injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis <input type="checkbox"/> 16. Any blood disorder such as Anemia or Hemophilia <input type="checkbox"/> 17. Aneurysm (Aortic or Cerebral), Blood Clot, TIA or Stroke <input type="checkbox"/> 18. AIDS, HIV, Chronic Fatigue Syndrome, any Immune Suppressed Illness <input type="checkbox"/> 19. Depression, Anxiety, ADD, ADHD, Psychotic Disorder <input type="checkbox"/> 20. Any Drug or Alcohol Problems <input type="checkbox"/> 21. Any Stem Cell or Organ Transplant (planned, recommended or already performed) <input type="checkbox"/> 22. Cigarette or Tobacco use? <input type="checkbox"/> 23. Any hospitalizations in the last 5 years (Please give full details below) <input type="checkbox"/> 24. Any future surgeries discussed, planned or recommended (Please give full details below) <input type="checkbox"/> 25. Currently taking any prescription medications? Please give details below to include the name of the medication and condition for which the medication is needed. <input type="checkbox"/> 26. Are there any other medical conditions not listed above? (Please give full details below) <input type="checkbox"/> 27. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

Employee Name: _____

Employer Name: _____

EXPLANATION SECTION

Provide an explanation for each box marked in questions 1 - 27. 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. 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.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Medications	Date of most recent inpatient stay		Is ongoing treatment required?	If yes, please explain
						From	To		
List prescription medications not in response to the questions listed above									

OTHER INFORMATION (CONTINUE ON A SEPARATE SHEET OF PAPER IF NECESSARY)

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 _____