

## HOW TO COMPLETE YOUR ENROLLMENT APPLICATION

Following are instructions for completing the Enrollment Application.

**Remove instruction sheet to complete application.**

All information must be completed as indicated.

### EMPLOYEE INFORMATION

Items 1 through 5 and 10 through 14 ask for information regarding the employee. The information you must complete includes:

- 1) Reason for Application – Please check the appropriate box indicating reason for application.
- 2) Hire Date of the Employee.
- 3) Employee Status: Please check the appropriate box(es) indicating whether you are an Active, Retired, Hourly or Salary employee.
- 4) Employee Home Phone Number (including area code)
- 5) Employee Work Phone Number (including area code)

**Items 6 through 9 should be completed by your Account Administrator.**

- 10) Employer Name.
- 11) Association Name – Please indicate if your Employer is part of an association.
- 12) Employee Last Name, First Name and Middle Initial.
- 13) Employee Street Address, City, State, and Zip Code.
- 14) Check or write in Type of Product and Type of Coverage for which you are enrolling using the appropriate category (employee, insured & spouse/domestic partner, parent and child, parent and children, or family).

Items 15 through 23 ask for important information about yourself and each eligible member of your family. Please complete the following information for yourself, your spouse/domestic partner, or your child/dependent. Please indicate the relationship to the employee according to the Relation Codes provided below the ELIGIBLE PARTICIPANTS section.

- 15) Last Name, First Name – Complete the last and first name for each eligible person listed.
- 16) Relation Code – Please indicate the appropriate Relation Code for each eligible participant. Please refer to the key (+) provided on the application below the ELIGIBLE PARTICIPANTS section.
- 17) Birth Date (month, day, century and year).
- 18) Identification Number.
- 19) Full Name of Primary Care Physician (PCP) / Group Practice from Directory – Indicate the name of the Primary Care Physician (PCP) or Group Practice selected from the Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different PCP.
- 20) Are you an existing Patient of this PCP? – Please check “Yes” or “No” to indicate if you are currently a patient of the PCP you chose.
- 21) Primary Care Physician (PCP) Number from Directory – Please indicate the corresponding number for the physician you or your dependent chose as a PCP from the Provider Directory.
- 22) Directory Network Code – Please indicate the Directory Network Code which is located on the front cover of your Provider Directory.
- 23) Complete if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Refer to your Medicare card to complete the Medicare Information Section.
- 24) You and your employer must sign and date the form where indicated.

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

### ENROLLMENT APPLICATION

PLEASE PRINT (COMPLETE ALL BUT THE SHADED AREAS)

1. REASON FOR APPLICATION <input type="checkbox"/> ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> REHIRE <input type="checkbox"/> COBRA <input type="checkbox"/> OTHER:		2. HIRE DATE	3. STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> HOURLY <input type="checkbox"/> RETIREE <input type="checkbox"/> SALARY		4. HOME TELEPHONE # ( )	5. WORK TELEPHONE # ( )	6. EFFECTIVE DATE	7. GROUP NUMBER	8. PAYROLL LOCATION #	9. CLOCK #																																				
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ELIGIBLE PARTICIPANTS (If you have additional dependents, attach separate sheet.)

15. LAST NAME, FIRST NAME, M.I.	16. RELATION CODE SELF <input type="checkbox"/> M (01) <input type="checkbox"/> F (04)	17. BIRTHDATE MM / DD / YYYY	18. IDENTIFICATION NUMBER	19. FULL NAME OF PRIMARY CARE PHYSICIAN (PCP)	20. ESTABLISHED PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	21. PCP NUMBER FROM DIRECTORY	22. DIRECTORY NETWORK CODE
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.* +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
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23. Please check one if applicable (if additional space is required, attach a separate sheet). If you <input type="checkbox"/> , your spouse/domestic partner <input type="checkbox"/> , or dependent(s) <input type="checkbox"/> , are enrolled in another Program, please give the following information:  Name of Employer (if applicable): _____ Group No: _____ Name of Insurance Carrier: _____ Effective Date: _____ Name of Insured: _____ Policy Number: _____ Insurance Carrier Phone # _____	<b>MEDICARE INFORMATION:</b> List any family member that is eligible for Medicare Benefits:															
	<table border="1"> <thead> <tr> <th>Name of Member</th> <th>Health Insurance Claim Number</th> <th>Part A Effective Date (Mo-Day-Yr)</th> <th>Part B Effective Date (Mo-Day-Yr)</th> </tr> </thead> <tbody> <tr> <td>Last First</td> <td></td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td></td> <td></td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td></td> <td></td> <td>/ /</td> <td>/ /</td> </tr> </tbody> </table> <p>Do you have a Medicare Supplement or other coverage that complements Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Name of Member	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Last First		/ /	/ /			/ /	/ /			/ /
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24. I certify that the information provided on this application is true to the best of my knowledge. 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.

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PLAN USE ONLY	Blue Shield Plan	Blue Cross Plan	Major Med. Plan	Dental					Vision					Drug								
				Basic	A	B	C	D	E	Basic	A	B	C	D	E	Basic	A	B	C	D	E	

Blue Shield Plan Area	Blue Cross Plan Area	Major Med. Plan Area	Dental Plan Area	Vision Plan Area	Drug Plan Area

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DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																															
VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																															
DRUG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																															
13. ADDRESS - STREET CITY STATE ZIP																																																				

ELIGIBLE PARTICIPANTS (If you have additional dependents, attach separate sheet.)

15. LAST NAME, FIRST NAME, M.I.	16. RELATION CODE SELF <input type="checkbox"/> M (01) <input type="checkbox"/> F (04)	17. BIRTHDATE MM / DD / YYYY	18. IDENTIFICATION NUMBER	19. FULL NAME OF PRIMARY CARE PHYSICIAN (PCP)	20. ESTABLISHED PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	21. PCP NUMBER FROM DIRECTORY	22. DIRECTORY NETWORK CODE
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.* +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
	SPECIFY CODE: +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
	SPECIFY CODE: +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
	SPECIFY CODE: +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
	SPECIFY CODE: +	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		

+ Relation Codes: 02 - Male Spouse, 03 - Son, 05 - Female Spouse, 06 - Daughter, 07 - Male with Disability, 08 - Female with Disability, 09 - Student Male (age 19 or older), 10 - Student Female (age 19 or older), 11 - Grandson, Nephew, Brother, 12 - Granddaughter, Niece, Sister, 13 - Stepson, 14 - Stepdaughter, 17 - Male Domestic Partner, 18 - Female Domestic Partner

23. Please check one if applicable (if additional space is required, attach a separate sheet). If you <input type="checkbox"/> , your spouse/domestic partner <input type="checkbox"/> , or dependent(s) <input type="checkbox"/> , are enrolled in another Program, please give the following information:  Name of Employer (if applicable): _____ Group No: _____ Name of Insurance Carrier: _____ Effective Date: _____ Name of Insured: _____ Policy Number: _____ Insurance Carrier Phone # _____	<b>MEDICARE INFORMATION:</b> List any family member that is eligible for Medicare Benefits: <table border="1"> <thead> <tr> <th>Name of Member</th> <th>Health Insurance Claim Number</th> <th>Part A Effective Date (Mo-Day-Yr)</th> <th>Part B Effective Date (Mo-Day-Yr)</th> </tr> </thead> <tbody> <tr> <td>Last First</td> <td></td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td></td> <td></td> <td>/ /</td> <td>/ /</td> </tr> <tr> <td></td> <td></td> <td>/ /</td> <td>/ /</td> </tr> </tbody> </table>	Name of Member	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Last First		/ /	/ /			/ /	/ /			/ /	/ /
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Last First		/ /	/ /														
		/ /	/ /														
		/ /	/ /														
	Do you have a Medicare Supplement or other coverage that complements Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No																

24. I certify that the information provided on this application is true to the best of my knowledge. 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.

SIGNATURE OF EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_ AUTHORIZATION - EMPLOYER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_