



Capital BlueCross

Capital BlueCross and its subsidiary,
Capital Advantage Insurance Company® (collectively "Capital")
Independent Licensees of the Blue Cross and Blue Shield Association

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

*Dependable Health Care Coverage from the
Capital Blue Cross Family of Companies*

Capital BlueCross
Account Administration
PO Box 772616
Harrisburg, PA 17177-2616

INSTRUCTION SHEET

1-800-962-2242
www.capbluecross.com

The Group Administrator must complete all shaded sections before an application is submitted to Capital BlueCross and/or its wholly owned subsidiary, Capital Advantage Insurance Company® (collectively, "Capital").

GROUP INFORMATION (For Group Administrator Use) – Print the Employer's Name, Group Name (if different from employer's name), and Group Number/Subgroup Number assigned by Capital. Indicate if the waiting period has been met. Print the Employer's Address (for Association Groups), Effective Date of Coverage/Change, and Date Hired. Indicate if your company employs 20 or more employees. Complete the Class of the Subscriber.

TYPE OF ACTIVITY (For Group Administrator Use) – Check the appropriate box to indicate whether the subscriber is enrolling in, changing, or terminating group coverage.

REASON CODES (For Group Administrator Use) – Place a check mark in the appropriate box to indicate the reason for completing the application. If the reason is due to an initial eligibility, life status change, or termination of a subscriber or subscriber's dependent, enter the appropriate code and date the change occurred. (If multiple changes occur, use the code most applicable.) Refer to the back of the application for appropriate codes and descriptions.

Please send the completed application to:
Capital BlueCross
Account Administration
PO Box 772616
Harrisburg, PA 17177-2616

INSTRUCTIONS TO SUBSCRIBER

IMPORTANT: Print Clearly and complete this form accurately to help us process your enrollment or change information as quickly as possible.

If you have any questions about completing the Enrollment/Change Form, have your Group Administrator help you or call Customer Service at 1-800-962-2242. We'll be glad to help you.

- SUBSCRIBER INFORMATION** – Clearly print your Subscriber Identification/Social Security Number and Birth Date. Check the appropriate boxes indicating your sex and marital status. Print your Name (Last, First, Middle Initial), current Mailing Address, and provide your Home and Work Phone Numbers including Extension. Check the appropriate box for Employment Status and print the Average Number of Hours Worked Per Week. When making only an address change, print your Subscriber Identification/Social Security Number, Name (Last, First, Middle Initial), new Mailing Address, and check the "Yes" block for "New Address." Provide your Home Phone Number and complete section 8.
- ENROLLMENT/CHANGE INFORMATION** – Print the Name (First, Middle Initial and Last Name if different from the subscriber) of all your dependents who are eligible for health care coverage and who are to be enrolled under your

contract. Check the appropriate box to indicate sex of spouse and each dependent's relationship to you. (If the dependent is other than a son or daughter, write the relationship in the space titled "OTHER"). Print the Social Security Number and the full Birth Date of each dependent. Be sure to indicate whether the dependent is being "added" or "removed" by checking the appropriate box.

- COVERAGE SELECTION** – Select the coverage for which you (and/or your dependents) are applying or to which you are changing. If you are adding a product and multiple benefit levels are offered (i.e., "high," "low," "1," "2"), indicate the benefit level chosen in the column. Otherwise, place an "A" to add, or "R" to remove in the column. If you are unsure which types of coverage you now have, or are eligible to add, contact your Group Administrator.
- PRIMARY CARE PHYSICIAN (PCP)** – Selection of a Primary Care Physician is dependent on your coverage. With **POS** coverage, selection of a PCP is required, and in order to obtain the highest level of benefits, the selected PCP must provide referrals for non-emergency specialty and other care. With **PPO+** coverage, selection of a PCP is purely **voluntary**, and specialty care from participating providers may be accessed directly, without a PCP referral. Indicate your choice for your PCP by his/her practice name and PCP code number (found in your Provider Network Directory). You and each member of your family can select his or her own PCP from the Directory.
- HANDICAPPED DEPENDENTS** – List the names of any handicapped dependents enrolled under your contract. If this section is completed, additional information may be sent to you.
- MEDICARE INFORMATION** – Complete this section only if you or your dependents are eligible for Medicare benefits. Print the Medicare Claim Number and effective date(s) found on your red, white, and blue Medicare Health Insurance Card. Check the appropriate box to indicate whether you or any of your dependents are classified as disabled under Medicare or eligible for Medicare benefits due to End Stage Renal Disease (ESRD).
- OTHER INSURANCE COVERAGE** – Complete this section if you and/or any of your dependents currently have health care coverage with another Blue plan, HMO, managed care plan, or other insurance company. Print the Name of each person holding the contract, the Name of the health care plan or insurance company, and the Identification or Policy Number. If this section is completed, additional information may be sent to you.
- STUDENT INFORMATION** – Complete this section if any of your dependents are 19 years of age or older and a full-time student at an accredited school or university. Print the name of the dependent(s), the name of the school or university, and the anticipated graduation date(s).
- CHANGE INFORMATION** – Complete this section to make a change in Name, Social Security Number, or Birth Date for you or a dependent. Place a check mark in the appropriate box to indicate if the change is for you or the dependent. Print the current information in the "FROM" block and the new or correct information in the "TO" block.
- STATEMENT OF APPLICATION** – Read this section carefully. You must sign and date the application for it to be processed. Capital will not accept your application if this section is not completed.

Tear off this page and use it to help you complete this form. Then discard.



Capital BlueCross and its subsidiary,
Capital Advantage Insurance Company* (collectively "Capital")
Independent Licensees of the Blue Cross and Blue Shield Association

1-800-962-2242 www.capbluecross.com

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

GROUP ADMINISTRATOR: Please complete shaded area of form

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION:

Subscriber Identification (Social Security Number) _____ / _____ / _____	Birth Date _____ / _____ / _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber Name (Last, First, M.I.) _____		<input type="checkbox"/> Single <input type="checkbox"/> Married
Mailing Address (Include street address, city, state and ZIP Code) _____		(New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No) County _____
Home Phone Number (____) _____	Work Phone Number / Ext. (____) _____	
Employment Status: <input type="checkbox"/> Active (Full-Time) <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Average Number of Hours Worked Per Week _____	<input type="checkbox"/> Active (Part-Time) <input type="checkbox"/> Salary <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union	

Employer's Name _____	
Group Name (if different from above) _____	
Group Number _____	Subgroup Number _____ Class _____
Does your company employ 20 or more employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer's Address (for Association Groups Only) _____	
Effective Date of Coverage/Change: _____ / _____ / _____	
Date Hired _____ / _____ / _____	Has waiting period been met? <input type="checkbox"/> Yes <input type="checkbox"/> No
TYPE OF ACTIVITY	
<input type="checkbox"/> Enrollment <input type="checkbox"/> Change of Enrollment <input type="checkbox"/> Termination	
REASON CODES (See back for codes and descriptions)	
<input type="checkbox"/> Open Enrollment	
<input type="checkbox"/> Life Status Change: CODE _____	Date of Change _____ / _____ / _____
<input type="checkbox"/> Initial Eligibility Change: CODE _____	Date of Change _____ / _____ / _____
<input type="checkbox"/> Termination: CODE _____	Date of Change _____ / _____ / _____
<input type="checkbox"/> Other (Please Explain) _____	

2. ENROLLMENT/CHANGE INFORMATION

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date
SUBSCRIBER		
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female		____ / ____ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Dau		____ / ____ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Dau		____ / ____ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Dau		____ / ____ / ____
<input type="checkbox"/> Other		____ / ____ / ____

3. COVERAGE SELECTION/CHANGE

ADD or REMOVE?	Trad.	Comp.	Options	PPO	PPO+	POS	Senior	Dental	Vision	Drug
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										

4. PRIMARY CARE PHYSICIAN

Indicate Practice Names & Codes (Refer to Network Provider Directory)

5. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

6. MEDICARE COVERAGE INFORMATION

Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s)		Disabled?	ESRD?
		Hospital (Part A)	Medical (Part B)		
		____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have any other health care coverage with a Blue plan OR other insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed)

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

8. STUDENT INFORMATION

Complete the following information for DEPENDENTS who are 19 YEARS OLD OR OLDER and enrolled as full-time students at an accredited school or college/university. (Please attach a separate sheet of paper if additional space is needed)

Student's Name	Name of School or College/University	Expected Date of Graduation
		____ / ____ / ____

9. CHANGE THE FOLLOWING INFORMATION

Change is for Subscriber Dependent (Name)

Name	From _____	To _____
Birth Date	From _____ / _____ / _____	To _____ / _____ / _____
Social Security Number	From _____ / _____ / _____	To _____ / _____ / _____

10. STATEMENT OF APPLICATION

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature _____ Date _____



Capital BlueCross and its subsidiary,
Capital Advantage Insurance Company (collectively "Capital")
Independent Licensees of the Blue Cross and Blue Shield Association

1-800-962-2242 www.capbluecross.com

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

GROUP ADMINISTRATOR: Please complete shaded area of form

Employer's Name	
Group Name (if different from above)	
Group Number	Subgroup Number
Class	
Does your company employ 20 or more employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer's Address (for Association Groups Only)	
Effective Date of Coverage/Change: / /	
Date Hired / /	Has waiting period been met? <input type="checkbox"/> Yes <input type="checkbox"/> No
TYPE OF ACTIVITY	
<input type="checkbox"/> Enrollment <input type="checkbox"/> Change of Enrollment <input type="checkbox"/> Termination	
REASON CODES (See back for codes and descriptions)	
<input type="checkbox"/> Open Enrollment	
<input type="checkbox"/> Life Status Change: CODE	Date of Change / /
<input type="checkbox"/> Initial Eligibility Change: CODE	Date of Change / /
<input type="checkbox"/> Termination: CODE	Date of Change / /
<input type="checkbox"/> Other (Please Explain) Date of Change / /	

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION:	
Subscriber Identification (Social Security Number) _____ / _____ / _____	Birth Date / / <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber Name (Last, First, M.I.) <input type="checkbox"/> Single <input type="checkbox"/> Married	
Mailing Address (Include street address, city, state and ZIP Code)	(New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No) County
Home Phone Number () ()	Work Phone Number / Ext. () ()
Employment Status: <input type="checkbox"/> Active (Full-Time) <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Non-Union	Average Number of Hours Worked Per Week
<input type="checkbox"/> Active (Part-Time) <input type="checkbox"/> Salary <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union	

2. ENROLLMENT/CHANGE INFORMATION				3. COVERAGE SELECTION/CHANGE										4. PRIMARY CARE PHYSICIAN	
First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	Options	PPO	PPO+	POS	Senior	Dental	Vision	Drug	Indicate Practice Names & Codes (Refer to Network Provider Directory)	
SUBSCRIBER			<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
<input type="checkbox"/> Other		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE												
Dependent Address if different from Subscriber				Place an "A" to ADD Coverage or an "R" to REMOVE Coverage For the issuer(s) of these coverages, please see reverse side.											

5. HANDICAPPED DEPENDENTS		6. MEDICARE COVERAGE INFORMATION					
Name of Handicapped Dependent	Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. (Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)	Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s)		Disabled?	ESRD?
				Hospital (Part A)	Medical (Part B)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. OTHER INSURANCE COVERAGE			8. STUDENT INFORMATION		
Complete if YOU or ANY OF YOUR DEPENDENTS have any other health care coverage with a Blue plan OR other insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed)			Complete the following information for DEPENDENTS who are 19 YEARS OLD OR OLDER and enrolled as full-time students at an accredited school or college/university. (Please attach a separate sheet of paper if additional space is needed)		
Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number	Student's Name	Name of School or College/University	Expected Date of Graduation
					/
					/

9. CHANGE THE FOLLOWING INFORMATION			10. STATEMENT OF APPLICATION	
Change is for <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent (Name)			By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.	
Name	From	To		
Birth Date	From / /	To / /		
Social Security Number	From _____ / _____ / _____	To _____ / _____ / _____		
			Subscriber's Signature	Date

INITIAL ELIGIBILITY:

<u>Code</u>	<u>Definition</u>
-------------	-------------------

- | | |
|----|---|
| A: | New group enrollment and/or group medical only benefit change. |
| B: | Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group. |
| C: | The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent). |
| D: | The Association acquires a new employer group. |
| E: | Union member now eligible for coverage. |

LIFE STATUS CHANGES (If multiple changes occur, use the code most applicable):

<u>Code</u>	<u>Definition</u>
-------------	-------------------

- | | |
|----|--|
| F: | The subscriber marries. |
| G: | The subscriber has a child, adopts, acquires a stepchild, or becomes legal guardian of a child. |
| H: | The subscriber divorces or legally separates and no longer has coverage through a spouse. |
| I: | The subscriber has a change in employment status (i.e., from part-time to full-time, hourly to salary, union to nonunion). |
| J: | The subscriber or dependent has a change in his/her Medicare Primary Status (i.e., the employee becomes Medicare Primary). |
| K: | The subscriber and/or dependent loses coverage under another benefit plan. |
| L: | The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.). |

SUBSCRIBER TERMINATIONS (Including all dependents):

<u>Code</u>	<u>Definition</u>
-------------	-------------------

- | | |
|-----|---|
| 01: | The subscriber is no longer employed/requests cancel. |
| 03: | The subscriber is deceased. |
| 04: | The contract cancel reason is unknown. |
| 05: | The subscriber has coverage with another Blue plan. |
| 33: | The subscriber selected coverage through another insurance company. |

DEPENDENT TERMINATIONS:

<u>Code</u>	<u>Definition</u>
-------------	-------------------

- | | |
|-----|---|
| 03: | The dependent is deceased. |
| 05: | The dependent has coverage with another Blue plan. |
| 08: | The dependent marries. |
| 09: | The dependent is over the age limit. |
| 10: | The dependent is divorced. |
| 11: | The dependent is separated. |
| 33: | The dependent has coverage through another insurance company. |

OTHER/EXPLANATION:

If the reason for the enrollment/change is other than listed above, please explain on the front of the application.

The Traditional program consists of hospitalization issued by Capital BlueCross (CBC) and medical/surgical and major medical coverage issued by its wholly owned subsidiary, Capital Advantage Insurance Company® (CAIC). The Comprehensive, PPO, **PPO+**, **POS**, Senior, and Options programs are issued by CAIC. Prescription drug card coverage is issued by CBC. Dental and vision coverages are issued by independent insurance companies.

STATEMENT OF APPLICATION

To Capital BlueCross and Capital Advantage Insurance Company® (collectively “Capital”):

I hereby apply for the coverage indicated. I understand this application is subject to approval by Capital, their subsidiaries, and/or reinsurers, and any coverage provided will be subject to the terms of the agreements and/or contracts issued to me. **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 verify that the information supplied by me is correct to the best of my knowledge, information, and belief.