

## HOW TO COMPLETE YOUR HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Following are instructions for completing the Highmark 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
- 2) Employee First Name, skip a space, Last Name. (no middle initial)
- 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
- 10) Employee Daytime Phone Number (including area code)
- 11) Employee Evening Phone Number (including area code)
- 12) Employee Date of Hire
- 13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

Items **14** through **18** ask for important information about yourself and each eligible member of your family (**14** yourself, **15** your spouse/ domestic partner, **16-18** your dependents). Please complete all requested information. If relationship is "other", please indicate the dependent's relationship to you according to the codes provided on the application.

- **First Name/Last Name**—Complete the first and last name for each eligible person listed. Skip a space between first and last name. Do not use a middle initial.
  - **Social Security Number**—Please include the Social Security Number of each person.
  - **Birth Date** (month/day/year)
  - **Sex** (female or male)
  - **Check if: Student over 19 and/or Disabled**—If your dependent is over the age of 19 and a full time student or a disabled dependent of any age, please check (✓) the appropriate column by that dependent's name.
- 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.
  - 20) Should be completed by your account administrator.
  - 21) You must sign and date the form where indicated.
  - 22) Do not complete any of the information below the Employee Signature and Date.

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

# HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.



P.O. Box 890172  
Camp Hill, PA 17089

I N F O R M A T I O N	1) Employer Name													
	2) Employee First Name / Last Name													
	3) Street Address						4) City			5) State		6) Zip		
	7) Social Security Number				8) Effective Date of Coverage Mo Day Year				9) Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salary					
	10) Employee Phone #—Day ( ) ( ) ( )			11) Employee Phone #—Evening ( ) ( ) ( )			Mo Day		12) Hire Date Year					

13) Check Type of Coverage	MEDICAL	VISION	DRUG	PRODUCT NAME
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured & Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete items 14 through 19 where applicable. List eligible participants (If you have additional dependents, attach separate sheet)

14) Complete Where Applicable	First Name / Middle Initial / Last Name	Social Security Number	Birth Date			Sex F/M	Check If	
			Mo	Dy	Yr		Student Over 19	Dis-abled
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*								

\*If "domestic partner" or "other" applies, complete using one of the following codes: —Grandson, Nephew, Brother (11), —Granddaughter, Niece, Sister (12), —Stepson (13), —Stepdaughter (14) —Male Domestic Partner (17) —Female Domestic Partner (18)

<p>19) 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 or Medicare, please give the following information:</p> <p>Name of Employer (If applicable): _____ Group No: _____</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identification Number: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance Carrier Phone #: _____</p>	<p>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 or Medicare, please give the following information:</p> <p>Name of Employer (If applicable): _____ Group No: _____</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identification Number: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance Carrier Phone #: _____</p>
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I certify that the information provided on this form 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 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 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.

20) \_\_\_\_\_  
Authorized Employer Signature Date

21) \_\_\_\_\_  
Employee Signature Date

To be completed by Account/Administrator only

22) Group Number	Payroll Number	Clock Number
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PLAN USE ONLY	PR Plan	FA Plan	MM Plan	Dental					Vision					Drug								
				Basic	A	B	C	D	E	Basic	A	B	C	D	E	Basic	A	B	C	D	E	
	PR Plan Area	FA Plan Area	MM Plan Area	Dental Plan Area	Vision Plan Area		Drug Plan Area															

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Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.



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I N F O R M A T I O N	1) Employer Name													
	2) Employee First Name / Last Name													
	3) Street Address						4) City			5) State		6) Zip		
	7) Social Security Number				8) Effective Date of Coverage Mo Day Year				9) Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salary					
	10) Employee Phone #—Day ( ) ( ) ( ) ( ) ( ) ( )				11) Employee Phone #—Evening ( ) ( ) ( ) ( ) ( ) ( )				12) Hire Date Mo Day Year					

13) Check Type of Coverage

MEDICAL	VISION	DRUG	PRODUCT NAME
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"/>

Complete items 14 through 19 where applicable. List eligible participants (If you have additional dependents, attach separate sheet)

Complete Where Applicable	First Name / Middle Initial / Last Name	Social Security Number	Birth Date			Sex F/M	Check If	
			Mo	Dy	Yr		Student Over 19	Dis-abled
14) Self								
15) <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*								
16) <input type="checkbox"/> Child <input type="checkbox"/> Other*								
17) <input type="checkbox"/> Child <input type="checkbox"/> Other*								
18) <input type="checkbox"/> Child <input type="checkbox"/> Other*								

\*If "domestic partner" or "other" applies, complete using one of the following codes: —Grandson, Nephew, Brother (11), —Granddaughter, Niece, Sister (12), —Stepson (13), —Stepdaughter (14) —Male Domestic Partner (17) —Female Domestic Partner (18)

<p>19) 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 or Medicare, please give the following information:</p> <p>Name of Employer (If applicable): _____ Group No: _____</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identification Number: _____</p> <p>Insurance Carrier Phone #: _____</p>	<p>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 or Medicare, please give the following information:</p> <p>Name of Employer (If applicable): _____ Group No: _____</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identification Number: _____</p> <p>Insurance Carrier Phone #: _____</p>
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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 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.

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22) Group Number	Payroll Number	Clock Number
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							Mo Day Year			<input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Retired <input type="checkbox"/> Salary				
10) Employee Phone #—Day				11) Employee Phone #—Evening				12) Hire Date						
( ) ( ) ( ) ( ) ( ) ( )				( ) ( ) ( ) ( ) ( ) ( )				Mo Day Year						

13) Check Type of Coverage	MEDICAL	VISION	DRUG	PRODUCT NAME
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured & Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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