

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) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 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.



An Independent Licensee of the Blue Cross and Blue Shield Association

Membership Department
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099



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PLEASE PRINT (COMPLETE ALL BUT THE SHADED AREAS)

ENROLLMENT APPLICATION

1. REASON FOR APPLICATION 2. EMPLOYEE HIRE DATE 3. STATUS 4. HOME TELEPHONE # 5. WORK TELEPHONE # 6. EFFECTIVE DATE 7. GROUP NUMBER 8. PAYROLL LOCATION # 9. CLOCK #
10. EMPLOYER NAME 11. ASSOCIATION NAME - IF APPLICABLE 14. CHECK TYPE OF COVERAGE EMPLOYEE ONLY IS SELECTING:
12. EMPLOYEE'S LAST NAME FIRST MI 14. HMO POS PRODUCT NAME: DENTAL VISION DRUG
13. ADDRESS - STREET CITY STATE ZIP

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

Table with columns: 15. LAST NAME, 16. RELATION CODE, 17. BIRTHDATE, 18. IDENTIFICATION NUMBER, 19. FULL NAME OF PRIMARY CARE PHYSICIAN (PCP), 20. ESTABLISHED PATIENT?, 21. PCP NUMBER FROM DIRECTORY, 22. DIRECTORY NETWORK CODE. Includes relation codes like Male Spouse, Female Spouse, etc.

23. Please check one if applicable (if additional space is required, attach a separate sheet). If you are enrolled in another Program, please give the following information:

Name of Employer (if applicable):
Name of Insurance Carrier:
Name of Insured:
Policy Number:
Insurance Carrier Phone #

24. 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. 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.

MEDICARE INFORMATION- List any family member that is eligible for Medicare Benefits:
Last Name of Member First Name of Member
Part A Effective Date (Mo-Day-'Yr)
Part B Effective Date (Mo-Day-'Yr)
Do you have a Medicare Supplement or other coverage that complements Medicare? Yes No

SIGNATURE OF EMPLOYEE DATE AUTHORIZATION - EMPLOYER SIGNATURE DATE

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ENROLL-1 (R12-04)

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ENROLLMENT APPLICATION

1. REASON FOR APPLICATION <input type="checkbox"/> NEW HIRE <input type="checkbox"/> REHIRE <input type="checkbox"/> OTHER:	2. EMPLOYEE HIRE DATE	3. STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIREE	4. HOME TELEPHONE # () ()	5. WORK TELEPHONE # () ()	6. EFFECTIVE DATE	7. GROUP NUMBER	8. PAYROLL LOCATION #	9. CLOCK #
10. EMPLOYER NAME	11. ASSOCIATION NAME - IF APPLICABLE		14. CHECK TYPE OF COVERAGE EMPLOYEE IS SELECTING: HMO <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> POS <input type="checkbox"/> INSURED & SPOUSE/ DOMESTIC PARTNER <input type="checkbox"/> PRODUCT NAME: <input type="checkbox"/> PARENT & CHILD <input type="checkbox"/> <input type="checkbox"/> PARENT & CHILDREN <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> DRUG <input type="checkbox"/>					
12. EMPLOYEE'S LAST NAME	FIRST	MI						
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	17. BIRTHDATE MM / DD / YYYY	18. IDENTIFICATION NUMBER	19. FULL NAME OF PRIMARY CARE PHYSICIAN (PCP)	20. ESTABLISHED PATIENT?	21. PCP NUMBER FROM DIRECTORY	22. DIRECTORY NETWORK CODE
	SELF <input type="checkbox"/> M (01) <input type="checkbox"/> F (04)	/ /			<input type="checkbox"/> YES <input type="checkbox"/> NO		
	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		

+ 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

PLAN USE ONLY	Blue Shield Plan		Blue Cross Plan		Major Med. Plan		Dental					Vision					Drug				
							A	B	C	D	E	A	B	C	D	E	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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Name of Insurance Carrier:
Name of Insured:
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24. 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.

MEDICARE INFORMATION- List any family member that is eligible for Medicare Benefits:
Last Name of Member First Name of Member
Part A Effective Date (Mo-Day-Yr) Part B Effective Date (Mo-Day-Yr)

Do you have a Medicare Supplement or other coverage that complements Medicare? Yes No
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

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