BlueCross of Northeastern Pennsylvania

Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Mark of the Blue Cross and Blue Shield Association

ENROLLMENT APPLICATION/CHANGE FORM FOR GROUP COVERAGE

Group Administrator

Must complete all information before enrollment will be processed. Form will be returned if not complete.

COMPANY NAME

MEDICAL GROUP NUMBER | AGENCY NUMBER | DENTAL GROUP NUMBER | VISION GROUP NUMBER

COMPANY NUMBER | DATE HIRED (MM/DD/YY) | EFFECTIVE DATE (MM/DD/YY)

MEDICAL COVERAGE

FIRST PRIORITY LIFE® Independent Licensee of the Blue Cross and Blue Shield Association

- ☐ BlueCare® Traditional
- ☐ BlueCare Comprehensive
- ☐ BlueCare PPO
- ☐ BlueCare QHD PPO
- ☐ BlueCare EPO

FIRST PRIORITY HEALTH Independent Licensee of the Blue Cross and Blue Shield Association

- ☐ BlueCare HMO
- ☐ BlueCare HMO Plus*

**Signature required on the Statement of Understanding of Financial Responsibility on back.*

BlueCross of Northeastern Pennsylvania Highmark BlueShield
Independent Licensees of the Blue Cross and Blue Shield Association
®Registered Marks of the Blue Cross and Blue Shield Association

- ☐ BlueCare Senior

For Administration Use Only

☐ **DAVIS VISION** Vision products are offered by HM Life Insurance Company,† administered by Davis Vision, Inc. This is not a Blue Cross product.

☐ **UNITED CONCORDIA DENTAL** Dental products are offered by United Concordia Life and Health Insurance.‡ This is not a Blue Cross product.

☐ **Enrolling in an HSA**

EMPLOYMENT TYPE

☐ New ☐ Rehire

Date rehired (MM/DD/YY)

☐ Retiree

☐ Open enrollment/qualifying life event

COBRA QUALIFYING EVENT/TERMINATION REASON

- ☐ Divorce/legal separation
- ☐ Voluntary termination of coverage
- ☐ Involuntary termination of coverage
  - Gross misconduct? ☐ Yes ☐ No
- ☐ Reduction of hours
- ☐ Death of covered employee
- ☐ Dependent child reached limiting age
- ☐ Layoff
- ☐ Disability leave expired
- ☐ Non-disability leave of absence expired

☐ COBRA event date

BEGIN DATE (MM/DD/YY)

END DATE (MM/DD/YY)

REASON

If you are making a change, please check the appropriate box and complete "Section 1. Applicant Information." If the change refers to a dependent, please complete "Section 2. Dependent Information" and the Supplemental Information for Dependent Enrollment form, if applicable.

DATE OF EVENT (MM/DD/YY)

- ☐ Changes to coverage
- ☐ New enrollment
- ☐ Group transfer
- ☐ Reinstatement
- ☐ Add dependent
- ☐ Add spouse
- ☐ Delete dependent/spouse
- ☐ New address
- ☐ Other (Specify):

Section 1. Applicant Information

Must complete all information before enrollment will be processed. Form will be returned if not complete.

GENDER ☐ M ☐ F

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

SOCIAL SECURITY NUMBER | DATE OF BIRTH (MM/DD/YY) | DAYTIME PHONE

ARE YOU THE EMPLOYEE? ☐ Yes ☐ No

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP. ☐ Current Patient

PCP or NPI (office #) | PRIMARY CARE PHYSICIAN | LOCATION/CITY

LAST NAME ☐ MR. ☐ MRS. ☐ MISS ☐ MS. | FIRST NAME | MI

STREET NUMBER | STREET NAME | CITY

STATE | ZIP | COUNTY | COUNTRY | PRIMARY LANGUAGE

EMAIL ADDRESS

DIFFERENT MAILING ADDRESS? ☐ Yes ☐ No If "Yes," all communications will be mailed to this address.

STREET NUMBER | STREET NAME | CITY

STATE | ZIP | COUNTY | COUNTRY

(continued on back)

† Vision products are offered by HM Life Insurance Company, administered by Davis Vision Inc. Davis Vision is an independent company and not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates.

‡ Dental products are offered by United Concordia Life and Health Insurance, an independent company and not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates.

03-B0044 11/10

Section 2. Dependent Information

Please list all family members to be covered. For changes, check "Add" or "Delete."

☐ ADD ☐ DELETE

☐ MEDICAL ☐ DENTAL ☐ VISION

PRIMARY LANGUAGE

SOCIAL SECURITY NUMBER – –

LAST NAME

FIRST NAME

MI

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.

☐ Current Patient

GENDER ☐ M ☐ F

DATE OF BIRTH (MM/DD/YY) / /

PCP or NPI (office #)

PRIMARY CARE PHYSICIAN

LOCATION/CITY

☐ ADD ☐ DELETE

☐☐☐

PRIMARY LANGUAGE

SOCIAL SECURITY NUMBER – –

LAST NAME

FIRST NAME

MI

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.

☐ Current Patient

GENDER ☐ M ☐ F

DATE OF BIRTH (MM/DD/YY) / /

PCP or NPI (office #)

PRIMARY CARE PHYSICIAN

LOCATION/CITY

☐ ADD ☐ DELETE

☐ MEDICAL ☐ DENTAL ☐ VISION

PRIMARY LANGUAGE

SOCIAL SECURITY NUMBER – –

LAST NAME

FIRST NAME

MI

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.

☐ Current Patient

GENDER ☐ M ☐ F

DATE OF BIRTH (MM/DD/YY) / /

PCP or NPI (office #)

PRIMARY CARE PHYSICIAN

LOCATION/CITY

If you answer "Yes" to any of these questions, you must complete and return the Supplemental Information for Dependent Enrollment form with this application.

Is the address for any dependents different from your residence address? ☐ Yes ☐ No

Do any dependents have a custodial parent who is responsible for their care? ☐ Yes ☐ No

Do you have other health insurance that will be in effect at the same time as this coverage? ☐ Yes ☐ No

Do any dependents have other group health insurance/Medicare? ☐ Yes ☐ No

Are any listed dependents over the dependent age and continuing as full-time students? ☐ Yes ☐ No

Are any listed dependents on this application disabled? ☐ Yes ☐ No

Section 3. General Applicant Information

Are you covered by Medicare? ☐ Yes ☐ No

If yes, reason for Medicare coverage (check all that apply): ☐ Age ☐ Disability ☐ ESRD

If "ESRD," date of dialysis (MM/DD/YY) / /

MEDICARE/HIC #

Do you have Medicare Part A? ☐ Yes ☐ No

If "Yes," effective (MM/DD/YY) / /

Do you have Medicare Part B? ☐ Yes ☐ No

If "Yes," effective (MM/DD/YY) / /

Provide a copy of your Medicare card with this application.

Section 4. Statement of Understanding of Financial Responsibility for BlueCare HMO Plus

I understand that treatment rendered by a provider in the First Priority Health (FPH) provider network will be paid at the highest level of benefits. I also understand that if there is no provider in the FPH network that can perform the service, and the service is medically necessary and appropriate, I can request prior authorization to use a BlueCard® or non-participating provider and receive care at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the FPH network and I will be responsible for the applicable deductible and coinsurance. I understand that my plan does not provide coverage for benefits received from a non-participating provider without prior approval from FPH. I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

Applicant Signature _____ **Date** _____

Section 5. Conditions of Enrollment

Please sign this section of the form. The form will not be processed without your signature.

I hereby apply for enrollment as checked hereon, made available to me through the groups with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and group literature indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents, listed above, to enroll them in a Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/ First Priority Health®/First Priority Life Insurance Company® health care plan. I authorize the Social Security Administration to furnish Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/First Priority Health, First Priority Life Insurance Co. medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. If enrolled in a First Priority Health product, I understand that treatment rendered by a provider in the First Priority Health provider network will be paid at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the First Priority Health network and I will be responsible for the applicable deductible and coinsurance. I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

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.

Applicant Signature _____ **Date** _____

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.

Group Administrator Signature (applies to all changes) _____ **Date** _____