BlueCross of Northeastern Pennsylvania

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

19 North Main Street
Wilkes-Barre, PA 18702

SUPPLEMENTAL INFORMATION FOR DEPENDENT ENROLLMENT

This form must be completed if you answered "yes" to any of the questions in the dependent information (2.) section of the Enrollment Application/Change Form. Please complete only the sections that pertain to your covered dependents and attach to your completed Enrollment Application/Change form for enrollment. Please be sure to sign the back of this form.

Applicant last name: ❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms. ❒ Sr. ❒ Jr.	First name:	Middle name:	Applicant Social Security Number:	
Is the address for dependents different from the primary residence address? ☐ Yes ☐ No If yes:				
Dependent 1 Last name: ❒ Sr. ❒ Jr.	Middle name:	First name:	Daytime phone:	
Residential address:	City	State:	ZIP:	County:
Dependent 2 Last name: ❒ Sr. ❒ Jr.	Middle name:	First name:	Daytime phone:	
Residential address:	City	State:	ZIP:	County:
Dependent 3 Last name: ❒ Sr. ❒ Jr.	Middle name:	First name:	Daytime phone:	
Residential address:	City	State:	ZIP:	County:
Dependent 4 Last name: ❒ Sr. ❒ Jr.	Middle name:	First name:	Daytime phone:	
Residential address:	City	State:	ZIP:	County:
Do any dependents have other group health insurance? ☐ Yes ☐ No If yes:				
Dependent name:	Social Security Number:		Date of birth: / /	
Insurance company name:	Insurance policy ID #:			
Insurance company address:	Type of coverage: ❒ Medical ❒ Dental ❒ Vision ❒ Rx			
Is anyone covered by Medicare? ☐ Yes ☐ No If yes:				
Dependent name:	Social Security Number:		Date of birth: / /	
Medicare/HIC #:				
Do you have Medicare Part A? ❒ Yes ❒ No	Part A begin date: / /		Part A end date: / /	
Do you have Medicare Part B? ❒ Yes ❒ No	Part B begin date: / /		Part B end date: / /	

Blue Cross of Northeastern Pennsylvania administers health care plans offered by Blue Cross of Northeastern Pennsylvania, Highmark Blue Shield, First Priority Health® and First Priority Life Insurance Company.℠

Please complete the reverse side of this form if applicable.

Is anyone covered on this application disabled? ☐ Yes ☐ No If yes:

Please complete a disabled dependent application, which you can get from your group administrator, from our website, www.bcnepa.com or by calling our service representatives at 1-800-829-8599 or (TTY) 1-866-280-0486.

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

Dependent name:		Social Security Number:		Date of birth: / /
Last name: ❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms. ❒ Sr. ❒ Jr.	Middle name:	First name:		Daytime phone:
Residential address:		City	State:	ZIP: County:

Is there someone who is financially responsible for the dependent? ☐ Yes* ☐ No If yes:

Dependent name:		Social Security Number:		Date of birth: / /
Organization/last name: ❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms. ❒ Sr. ❒ Jr.	Middle name:	First name:		Daytime phone:
Residential address:		City	State:	ZIP: County:

Are any dependents continuing coverage as full-time students? ☐ Yes ☐ No If yes:

Dependent name:		Social Security Number:		Date of birth: / /

Dependent marital status**:** ❒ Single ❒ Divorced ❒ Separated ❒ Married/date of marriage: / /

Dependent employment status:	Dependent student status: ❒ Full-time student ❒ Part-time student
❒ Full-time ❒ Part-time	School enrollment date: / / Expected date of graduation: / /

When your dependent child is no longer a full-time student, you must notify your employer through which you are enrolled. Failure to do so may result in the dependent not being able to continue his or her protection on a direct payment basis without a lapse in coverage.

Signature of applicant: _____ Date: _____

Signature of group administrator: _____ Date: _____

***A copy of a power of attorney or court-initiated document must be attached to this form in order for the custodial parent or responsible person to be applied.**