19 North Main Street, Wilkes-Barre, PA 18711 • www.bcnepa.com

Enrollment Application/Change Form for Group Coverage

Group Administrator

Must complete all information before enrollment will be processed. Please print CLEARLY using blue or black ink or type in information to avoid delay.

Type of Transaction ☐ Add ☐ Transfer ☐ Change ☐ Cancel

Reason: If you are making changes, please check the appropriate box and complete "Section 1. Applicant Information." If the change refers to a dependent, please **also** complete "Section 2. Dependent Information."

☐ Open Enrollment
☐ Rehire/Reinstatement (mm/dd/yyyy)
Date _____ /_____ /______

☐ COBRA (mm/dd/yyyy)
Begin Date _____ /_____ /______
End Date _____ /_____ /______

☐ New Address
☐ Other ______________________

☐ Add Dependent/Spouse
☐ Delete Dependent/Spouse
☐ Other ______________________

Date of Event (mm/dd/yyyy) ______ /______ /______
Type of Event ______________________
(e.g., Marriage, Newborn, Adoption, Divorce)

Company Name		Vision Group Number	Dental Group Number
Company Number	Medical Group Number	Department Number	Date Hired (mm/dd/yyyy) ______ /______ /______

Effective Date (mm/dd/yyyy) ______ /______ /______

Medical Coverage

First Priority Life®
☐ BlueCare® Traditional
☐ BlueCare PPO
☐ BlueCare QHD PPO
☐ BlueCare EPO
☐ BlueCare QHD EPO
☐ AffordaBlue℠

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

First Priority Health®
☐ BlueCare HMO
☐ BlueCare HMO Plus

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

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

Blue Cross of Northeastern Pennsylvania Highmark Blue Shield
☐ BlueCare Senior

This coverage does not duplicate Medicare benefits and is not a supplement to Medicare.

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

☐ **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.

Section 1. Applicant Information

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

Gender ☐ M ☐ F

Are you the Employee? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number	Date of Birth	Primary Phone Number	Alternate Phone Number

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a primary care physician (PCP)

PCP or NPI (Office Number)	Location/City	Primary Care Physician	Current Patient? ☐ Yes ☐ No

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Last Name	First Name	Middle Initial	Email Address

Current Address (Provide information below)

Street Number	Street Name		
City		State	Zip
County	Country		

Different Mailing Address? ☐ Yes ☐ No (If "Yes," all communications will be mailed to this address.)

Street Number	Street Name		
City		State	Zip
County	Country		

Do you have any other health insurance that will be in effect at the same time as this coverage? ☐ Yes ☐ No (If "Yes," please complete Section 3, "Other Health insurance Information.") (Applicant)

Section 2. Dependent Information

Please list all family members to be covered. For changes, check "Add" or "Delete." Attach additional sheets, if necessary.

Add	Delete	Social Security Number	Gender	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)	Medical	Dental	Vision	PCP or NPI	Primary Care Physician	Location	Current Patient
											If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you **must** select a PCP.			
☐	☐	Spouse						☐	☐	☐				☐
☐	☐							☐	☐	☐				☐
☐	☐							☐	☐	☐				☐
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* 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.

Section 2. Dependent Information (Continued)

2a. Is the address for any dependent(s) different from your residence address? ☐ Yes ☐ No (If "Yes," please complete the below section.)

If "Yes," Dependent Name	Street Number	Street Name	City	State	Zip	County

2b. Do any dependents have a custodial guardian who is responsible for their care? ☐ Yes* ☐ No (If "Yes," please complete the below section.)

If "Yes," Dependent(s) Name(s)	Dependent 1	Dependent 2	Dependent 3

Responsible Guardian Name	Street Number	Street Name	City	State	Zip	County

2c. Do any dependents have other health insurance coverage? ☐ Yes ☐ No (If "Yes," please complete the below section.)

Dependent 1	Insurance Company Name	Insurance Policy Number	Dependent 2	Insurance Company Name	Insurance Policy Number

2d. Do any dependents have Medicare coverage? ☐ Yes ☐ No (If "Yes," please complete the below section and provide a copy of the Medicare card(s).)

Dependent(s) Name(s)	Medicare HIC Number	Medicare Part A ☐ Yes ☐ No	Effective Date (mm/dd/yyyy)_______ /_______ /_______	Medicare Part B ☐ Yes ☐ No	Effective Date (mm/dd/yyyy)_______ /_______ /_______

2e. Is there someone else who is financially responsible for any dependents? ☐ Yes* ☐ No (If "Yes," please complete the below section.)

If "Yes," Dependent(s) Name(s)	Dependent 1	Dependent 2	Dependent 3

Responsible Party Name	Street Number	Street Name	City	State	Zip	County

2f. Are any dependent children over age 26 disabled? ☐ Yes ☐ No (If "Yes," please complete Disabled Dependent Application, which you can get from your group administrator, or from our website, www.bcnepa.com.)

2g. Are any listed dependents over the dependent age and continuing as full-time students? ☐ Yes ☐ No (If "Yes," please complete for each student and verify with employer, if required.)

Dependent Name	Expected Date of Graduation (mm/dd/yyyy)_______ /_______ /_______ Name of School	Dependent Name	Expected Date of Graduation (mm/dd/yyyy)_______ /_______ /_______ Name of School

Section 3. Other Health Insurance Information (Applicant)

Policy Holder Name	Insurance Company Name

Policy ID Number	Effective Date (mm/dd/yyyy)_______ /_______ /_______	Termination Date (mm/dd/yyyy)_______ /_______ /_______

Are you covered by Medicare? ☐ Yes ☐ No (If "Yes," please complete the below information.)

Medicare HIC Number	Please provide a copy of your Medicare card with this application

Medicare Part A ☐ Yes ☐ No	Effective Date (mm/dd/yyyy) _______ /_______ /_______	Medicare Part B ☐ Yes ☐ No	Effective Date (mm/dd/yyyy) _______ /_______ /_______

Section 4. Ethnic Background (Optional)

This information will not be used in considering your eligibility for benefits. No applicant will be excluded from coverage on the basis of race, color, creed, political beliefs, national origin, religion, age, gender or disability.

Complete this section for each person who will be covered under this policy

Make one selection for each category: Ethnicity; Race *Check all that apply*; Language

	Last Name	First Name	Hispanic/Latino	Not Hispanic/Latino	Decline	White	Black or African American	Asian	American Indian or Alaskan Native	Native Hawaiian or Other Pacific Islander	Other	Two or more races	Decline	English	Non-English	Decline
Applicant																
Spouse																
Dependent																
Dependent																
Dependent																
Dependent																

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 Company 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 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 nonparticipating 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 ______________________________ **Date** __________
(applies to all changes)

Section 6. 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 nonparticipating 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 nonparticipating 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** __________

For Administration Use Only

* 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.