HIGHMARK®

19 North Main Street • Wilkes-Barre PA 18711

ENROLLMENT FOR BENEFITS AWAY FROM HOME

1. INSURED INFORMATION (Please print or type.)

LAST NAME ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	FIRST NAME	MIDDLE NAME	EMAIL

SOCIAL SECURITY NUMBER	GROUP NUMBER	TYPE OF BENEFITS AWAY FROM HOME ENROLLMENT:	APPLYING FOR BENEFITS AWAY FROM HOME FOR:
___ ___ ___ - ___ ___ - ___ ___ ___ ___		❑ Student ❑ Long-term traveler ❑ Family apart	❑ Self ❑ Spouse ❑ Dependent child

MEDICAL COVERAGE:

❑ BlueCare Custom PPO ❑ BlueCare QHD Custom PPO ❑ AffordaBlue

2. BENEFITS AWAY FROM HOME ENROLLEE INFORMATION

LAST NAME ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	FIRST NAME	MIDDLE NAME	EMAIL

SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yyyy)	HOME PHONE	WORK PHONE	SEX ❑ Male ❑ Female
___ ___ ___ - ___ ___ - ___ ___ ___ ___				

STREET ADDRESS	CITY	STATE	ZIP	COUNTY	COUNTRY

3. SCHOOL INFORMATION (If Applying for Student Benefits Away From Home)

NAME OF COLLEGE/UNIVERSITY	CITY	STATE	ZIP	EXPECTED DATE OF GRADUATION (mm/dd/yyyy)

4. CONDITIONS OF ENROLLMENT

The above information is correct to the best of knowledge and I authorize release of any information requested with respect to this certification. I hereby authorize any insurance company, prepayment organization, employer, hospital, physician or other organization providing medical services to the dependent noted above to release any information or medical records with respect to the dependent noted above to Highmark and any of its affiliates or designees, as relates to any program providing benefits or services. 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.

Insured's signature _____ Date _____

Enrollee's signature (parent/guardian of minor) _____ Date _____

Group Administrator's signature _____ Date _____

FOR HIGHMARK BLUE CROSS BLUE SHIELD USE ONLY

CONTRACT NUMBER	GROUP NUMBER	EFFECTIVE DAVE	TERMINATION DATE

Note: Your benefits away from home coverage will become effective the first of the month following First Priority Life Insurance Company®'s receipt of the completed form and will remain in effect for a period of 6 continuous months. To continue your benefits away from home coverage without interrruption, a new form must be completed every 6 months and must be received by First Priority Life prior to your benefits away from home coverage termination date. Otherwise, your benefits away from home coverage will be terminated on the first of the month following the 6 continuous month period.

Please complete the entire form. This form will not be processed without the required signatures.
Contact the Customer Service number on the back of your ID card to receive information on where to send in the form.