



New Group     Existing

**PENNSYLVANIA MEDICAL SOCIETY  
2010 APPLICATION FOR GROUP BENEFITS**

Date Group Became Member In Association:

Group Name	Effective Date
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Street Address	City	State	ZIP	Telephone Number	Fax Number
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Replacing Current Carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Current Carrier	Cancellation Date	If Existing Highmark Blue Shield Customer, Please Provide Group Number(s):
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Description of Business:	SIC Code	New Employees Eligible to Enroll: <input type="checkbox"/> Date of Hire <input type="checkbox"/> Bill Date <input type="checkbox"/> 1 <sup>st</sup> Of Month Following Hire <input type="checkbox"/> Other, Specify _____	Hours Employees Must Work Per Week To Be Eligible For Coverage:
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Do you offer group coverage with other carriers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list other carriers' names: _____	No. of Employees with Other Carriers:	Employer Identification No. (EIN)
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TYPE OF COVERAGE	GROUP NUMBER	TYPE OF COVERAGE	GROUP NUMBER	TYPE OF COVERAGE	GROUP NUMBER
PPO High 100/80 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO Value \$1000 100/80 <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$3500 100/80 QHDHP copays	
PPO Standard 100/80 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO Value \$1500 100/80 <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$1500 100/80 QHDHP no copays	
PPO Basic 100/80 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO Value \$2000 100/80 <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$2600 100/80 QHDHP no copays	
PPO Basic 90/70 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO Value \$3000 100/80 <input type="checkbox"/> 8/50/50 <input type="checkbox"/> 8/50/70		PPO \$2600 90/70 QHDHP no copays	
PPO Value \$500 100/80 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$1250 100/80 QHDHP copays		Signature 65	
PPO Value \$500 90/70 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$1500 100/80 HDHP copays		BlueRx Option 4	
PPO 90/70 Rx: <input type="checkbox"/> 8/35/50 <input type="checkbox"/> 8/50/75		PPO \$2600 100/80 QHDHP copays		Vision: <input type="checkbox"/> Option I <input type="checkbox"/> Option V	

**SIGNATURES REQUIRED BELOW**

The applicant represents that by signing this application, he/she agrees that the group insurance described above will become effective upon acceptance of this application by the Company. Applicant further acknowledges that no coverage will be effective before the date determined by the Company. The Undersigned also acknowledge and understand that any person who knowingly and with the intent to defraud any insurer presents or conspires with another to present any statement in the support of an insurance claim that contains false information may be guilty of a criminal offense and subject to civil penalties to 18 Pa. C.S.A. 4117.

Group Policymaker and Title <i>(PRINT)</i>	Group Policymaker <i>(SIGNATURE)</i>	Date
Association Administrator <i>(SIGNATURE)</i>		Date

**HIGHMARK BLUE SHIELD UNDERWRITING USE ONLY**

Eligible	Enrolled	Approval: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Underwriting Control Analyst	Reviewer
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Comments: