

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder	
Policy Holder Date of Birth / /	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired - List Date of Retirement: / /		Relationship to Policyholder	Policy Number

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Self - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Spouse - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Dependent - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /

Health Insurance Claim Number	Why are you eligible for Medicare? <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease	Do you have a Medicare Supplement or other coverage that complements Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IMPORTANT: AUTHORIZED SIGNATURES (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

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.



Highmark
Attn: Producer Affairs (SP 6E)
P.O. Box 890089
Camp Hill, PA 17089-0089

Authorized Employer Signature _____ Date _____

Print Company Name _____

Employee Signature _____ Date _____

Print Employee's Name _____

**Office Use Only.
Do not write in
the spaces below.**

Group Number
Report Code Qualifier
Report Code Value