HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign.

HIGHMARK BLUE SHIELD

P.O. Box 890172
Camp Hill, PA

EMPLOYEE INFORMATION

1) Employer Name

Reason for application: ☐ Enrollment ☐ New Hire ☐ Rehire ☐ COBRA ☐ Other:

2) Employee First Name / Middle Initial / Last Name

3) Street Address | 4) City | 5) State | 6) Zip

7) Social Security Number | 8) Effective Date of Coverage | 9) Employee Status ☐ Active ☐ Retired (Date) _____ ☐ Hourly ☐ Salary

10) Employee Phone #--Home | 11) Employee Phone #--Work | 12) Employee Hire Date Month / Day / Year

13) Check Type of Coverage

	MEDICAL	VISION	DRUG	PRODUCT NAME
Employee only	☐	☐	☐	☐
Insured and Spouse/Domestic Partner	☐	☐	☐	☐
Family	☐	☐	☐	☐
Parent and Child	☐	☐	☐	☐
Parent and Children	☐	☐	☐	☐

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 19 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	Complete Where Applicable	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo	Dy	Yr	Sex F/M	Check if Student Over 19	Disabled
15)	Self			☐ Yes ☐ No If YES, then complete #20						
16)	☐ Spouse ☐ Dom.			☐ Yes ☐ No If YES, then complete #20						
17)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						
18)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						
19)	☐ Child ☐ Other*			☐ Yes ☐ No If YES, then complete #20						

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner.**

20) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status ☐ Active ☐ Retired (Date) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

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. I understand that this form enrolls those eligible persons listed above in the Medical Plan 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. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment, and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

21) _____
Authorization Employer Signature — Date

22) _____
Employee Signature — Date

6206 G (9-05)

HIGHMARK BLUE SHIELD COPY
ENR-6206 (R9-05)