ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

(Complete sections I, II, IV, and

A

(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)

Address

City	State	Zip	County	Home/Cell Phone

Marital Status (Please check one)
Single/Widowed   Married
Divorced

Enrollment Status
Active Employee   COBRA Continuant Start Date ____/____/____
Rehired Employee   HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)

Full-Time Hire (or Rehire) Date (Month/Day/Year)	Hours Worked Per Week	Job Title
/ /		

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
Male Female	/ /		Medical Product Name: ____________ Vision Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Pat
		Yes No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

/D C A

First Name	MI	Last Name	Relationship to You?
			Spouse Domestic Partner•

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
	Male Female	/ /	

Product Selection(s):
Medical   Vision   Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Establishe

Note: If spouse•s last name differs from the contract holder above, please attach a copy of your marriage certificate.

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D D C D

First Name	MI	Last Name	Relationship to You?
			Child Step-child Adopted* Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
	Male Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
Medical Vision Dental	Disabled Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Pat
		Yes No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

DEPENDENT CHILD

First Name MI Last Name Relationship to You? Child Step-child Adopted* Other*

Social Security Number (If no SS#, write N/A) Gender Male Female Date of Birth (Month/Day/Year) / / Age

Product Selection(s): Medical Vision Dependent Status if Age 26 or Older

DEPENDENT CHILD

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	E ective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			Active Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Bene“ts)

Name of Subscriber or Dependent	Health Insurance Claim Number	E ective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								Yes No
								Yes No
								Yes No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark 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 c

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 acknowledge and agree that any personally identi“able health information about me or my enrolled dependents (•Protected Health InformationŽ) 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 the Notice of Privacy Practices. I understand that a copy of Highmark•s Notice of Privacy Practices is available on Highmark•s Website, or from the Highmark Privacy O ce.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms t one of the following addresses:

Fax (800) 290-3301

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/Quality Assurance, or for a paper copy, call 1-855-873-4106.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on th back of your Member ID card to request these free services (TTY/TDD users may call 711).

Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) and First Priority Health (FPH) are independent licensees of the Blue Cross and Blue Shield Association.
Insurance may be provided by Highmark Blue Cross Blue Shield, FPLIC or FPH. Health care plans are subject to terms of the benefit agreement.