INSTRUCTIONS FOR COMPLETING YOUR ENROLLMENT/WAIVER APPLICATION AND CHANGE FORM

HIGHMARK® HEALTH INSURANCE COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

The descriptions below should be used when completing applicable sections of your Enrollment/Waiver Application and Change Form.

In the top right hand corner please list the Product Name under which you are enrolling. Then indicate the **Type of Coverage** that you have selected for you and your eligible dependents (e.g. employee only, two person, etc.)

Employee/Applicant Information (Section I): This section must always be completed even if your coverage has not changed.

- **Effective Date of Coverage –** The effective date of new coverage or, in the event of a change in existing coverage, the effective date of the change.
- **Group Number –** To be completed only if the reason for the application is COBRA, dependent status changes or addition of an Act 4 eligible dependent (i.e. qualified dependent up to Age 30.)

Covered Dependent Enrollment/Change Information (Section II): This section requires important information about yourself and each eligible member of your family. If relationship is "Domestic Partner" or "Other", please indicate the dependent's relationship to the employee using the codes provided on the application.

Do you have other insurance? – If you or your family members have other medical insurance, including Medicare, respond "yes." If not, you ***must*** respond "no."

- **Check If Disabled, Student over 19 or Act 4** (dependents up to age 30) – If your dependent is a full time student (age 19 or over), an eligible disabled dependent (any age) or entitled to enroll for coverage under Act 4 (qualified dependent up to age 30), please check the appropriate column by that dependent's name. Act 4 eligibility is at the discretion of the employer.
- **Dependent Changes –** If adding or terminating a dependent, check the appropriate box. Please be sure to include the date of the event leading to this change.
- **Other Changes –** This column should be used to indicate changes in either your coverage and/or that of your dependents. Please check the appropriate box and include the date of the event leading to this change.
- **Cancel/COBRA Reasons –** When you and/or your dependents enroll in COBRA, the reason must be indicated.
- **Additional Comments –** If additional space is needed to describe any changes, this can be documented in Section VIII.

Waiver Information (Section III): This section must be signed and indicate the reason why you are waiving group coverage for yourself and/or your dependents.

About Your Other Group or Non-Group Health Insurance Coverage and Medicare (Section IV): If you checked "yes" to the question "Do you have other insurance?" in Section II, then you must complete this section by identifying all other coverages each enrollee has.

Authorized Signature's (Required) (Section V): This section must be completed in all cases. Your signature authorizes the enrollment of you and your dependents under the coverage selected. Both your signature and your employer's signatures are required.

Medical History Information (Section VI): This section is to be completed for you and all eligible dependents you elect to enroll in this group coverage. This includes all dependents that you listed in Section II.

Explanation Section (Section VII): This section is to be used to provide detailed medical history information. Please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk.

Other Information (Section VIII): This section should be used to provide additional information and comments relating to your enrollment request.

Employee Signature (Section IX): Your signature is required in all cases when enrolling in group coverage. By signing this form, you are ensuring that all information provided in this application, including Sections VI-VIII is complete, true and accurate.

Reminder: In order for your request to be processed, you must complete each of the Sections indicated below:

Initial Enrollment: Complete Sections I, II, IV, V, VI, VII, VIII and IX

Waiving Coverage: Complete Sections I and III. Employer Signature Required on Section V.

Changing Existing Coverage: Complete Sections I, II, IV and V

Changing Existing Coverage and Adding Dependent(s): Complete Sections I, II, IV and V

An Independent Licensee of the Blue Cross and Blue Shield Association

Enrollment/Waiver Application and Change Form

Complete this application in its entirety in blue or black ink.
Do not use pencil or highlighter.

Product Name: ______

Check Type of Coverage	MEDICAL	VISION	DENTAL
Employee Only	❑	❑	❑
Two Person*	❑	❑	❑
Family	❑	❑	❑
Parent & Child	❑	❑	❑
Parent & Children	❑	❑	❑

*Employee and Spouse/Domestic Partner only

I. Employee/Applicant Information

Effective Date of Coverage / /	**Employer Name**		**Group Number**	
Employee Name - *First*	***Middle Initial***	***Last***	**Phone Number** ( )	
Street Address	**City**	**County**	**State**	**Zip Code**
Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced	**Employment Status** ❑ Active ❑ COBRA ❑ Disabled	**Date of Hire** / /	**Hours worked per week**	
Social Security Number	**Job Title**	**Email Address (optional)**		

Reason for Application
- ❑ **New Enrollee**
- ❑ **COBRA**
  Start Date: ______
  End Date: ______
- ❑ **Changes**
- ❑ **Act 4**
- ❑ **Qualifying Event**

II. Covered Dependent Enrollment/Change Information

Dependent Relationship. Complete as applicable	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo	Birth Date Dy	Birth Date Yr	Sex F/M	Check If: Dis-abled	Check If: Student Over 19	Check If: Act 4	Enrollment Changes: Dependent Changes	Enrollment Changes: Other Changes	Enrollment Changes: Cancel/COBRA Reasons
❑ Self			❑ Yes ❑ No If YES, complete top of next page									❑ Name Change ❑ New Address ❑ Change to Medicare Eligible ❑ Change Coverage ❑ Other:	❑ Deceased ❑ Left Employment ❑ Involuntary Lay-Off ❑ Other Coverage Date of Above Event: ______
❑ Spouse ❑ Dom. Part.*			❑ Yes ❑ No If YES, complete top of next page								❑ Marriage ❑ Divorce ❑ Death ❑ Other:	❑ Name Change ❑ New Address ❑ Change to Medicare Eligible ❑ Change Coverage	Date of Above Event: ______
❑ Child ❑ Other*			❑ Yes ❑ No If YES, complete top of next page								❑ Birth ❑ Adoption ❑ Death ❑ Other:	❑ Name Change ❑ New Address ❑ Change to Medicare Eligible ❑ Change Coverage	Date of Above Event: ______
❑ Child ❑ Other*			❑ Yes ❑ No If YES, complete top of next page								❑ Birth ❑ Adoption ❑ Death ❑ Other:	❑ Name Change ❑ New Address ❑ Change to Medicare Eligible ❑ Change Coverage	Date of Above Event: ______
❑ Child ❑ Other*			❑ Yes ❑ No If YES, complete top of next page								❑ Birth ❑ Adoption ❑ Death ❑ Other:	❑ Name Change ❑ New Address ❑ Change to Medicare Eligible ❑ Change Coverage	Date of Above Event: ______

***If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this application if relationship is "Other."**

III. Waiver Information

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S)

For: ❑ Medical ❑ Vision ❑ Dental

I hereby decline coverage:
- ❑ For myself
- ❑ For myself and **ALL** family members
- ❑ For family members **ONLY**
- ❑ For the following person(s): ______

Reason for declining coverage:
- ❑ Insured under own contract with: ______
- ❑ Insured under spouse's contract with the following insurance carrier: ______
- ❑ Do not have health coverage under any plan
- ❑ Other ______

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered.

______ *Signature* ______ *Date*

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

EMPLOYER SIGNATURE REQUIRED ON NEXT PAGE

IV. 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	Relationship to Policyholder	Policy Number
/ /	❑ Active ❑ Retired - List Date of Retirement: / /		

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

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

Health Insurance Claim Number	Why are you eligible for Medicare?	Do you have a Medicare Supplement or other coverage that complements Medicare?
	❑ Age ❑ Disability ❑ End Stage Renal Disease	❑ Yes ❑ No

V. 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.

Authorized Employer Signature *Date*

Print Company Name

Employee Signature *Date*

Print Employee's Name

HIGHMARK® HEALTH INSURANCE COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

Highmark
P.O. Box 890172
Camp Hill, PA 17089-0172

or

Fax to: 888-567-5685

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

Group Number
Report Code Qualifier
Report Code Value

VI. Medical History Information

Employee Name - *First*	*Last*	Social Security Number

Phone Numbers - *Home*	*Work*	*Cell*	Best number to reach you : ❑ Home ❑ Work ❑ Cell
( )	( )	( )	Best time to call:

Please answer each question below as completely as possible. **NOTE:** Medical information disclosed in this section will not be used to determine the eligibility of you and/or your dependents to enroll in the coverage requested. **If you or any of your dependents have EVER had any of the conditions listed below, please indicate by marking an "X" in each appropriate box.** Then, in the ***Explanation*** section on the next page, list the patient's name, diagnosis, treatment(s) and treatment date(s), surgeries and surgery date(s), and the prognosis for each condition marked.

*If additional space is needed, use Other Information (section VIII) Attach additional sheets if necessary.

Your Height	Your weight	Spouse's Height	Spouse's Weight
ft. in.	lbs.	ft. in.	lbs.

Dependent Name*	Height	Weight
	ft. in.	lbs.
	ft. in.	lbs.
	ft. in.	lbs.

1. CANCERS

❑ Presence or History of Cancer ❑ Yes ❑ No

If yes: Type/Location of cancer: __________

____

Currently treated: ❑ Yes ❑ No

If yes: Are IV's or infusions required ❑ Yes ❑ No

If yes: Are oral medications required? ❑ Yes ❑ No

2 TUMORS

❑ Presence or History of non-cancerous Tumors: ❑ Yes ❑ No

If yes: Type of Tumor _______________

Location of Tumor _______________

Operated: ❑ Yes ❑ No

3. HEART

❑ Anemia Type __________________

❑ Aneurysm Type __________________

Location _______________

❑ Blood Clot Type/Location _____________

❑ Coronary Artery Disease
Operated: ❑ Yes ❑ No

❑ Congenital Heart Disease
Type/Location __________________

❑ Congestive Heart Failure
< or > 6 months ___________________

❑ Heart Attack
❑ Single ❑ Multiple

❑ Hemophilia

❑ High Blood Pressure

❑ High Cholesterol

❑ Rheumatic Fever

❑ Rheumatic Heart Disease

❑ TIA < or > 3 months _______________

❑ Stroke < or > 1 year _______________

❑ Irregular or rapid heart beat

4. LUNG

❑ Apnea
❑ Use C-PAP ❑ Operated ❑ Newborn

❑ Asthma

❑ Allergy

❑ Cystic Fibrosis

❑ Emphysema

❑ Tuberculosis
❑ Current ❑ History of
❑ Positive skin test only

❑ COPD

5. HEART/LUNG TREATMENTS

❑ Angioplasty
❑ Single ❑ More than one

❑ Coronary Artery Bypass
❑ Single ❑ More than one

❑ Cardiac Catheterization

❑ Pace Maker or Defibrillator Implantation

❑ Heart Valve Replacement
❑ Mitral
❑ Operated or Asymptomatic
❑ Aortic
❑ Operated or Asymptomatic

6. IMMUNE

❑ AIDS

❑ HIV

❑ Any Immune Suppressed Illness

❑ Mononucleosis/Epstein Barr Virus

❑ Chronic Fatigue Syndrome
Injections
IM: ❑ Yes ❑ No
IV: ❑ Yes ❑ No

❑ Systemic Lupus < or > 1 year __________

7. RENAL

❑ Polycystic Kidney Disease: ❑ Operated

❑ Renal Failure
❑ Acute, Dialysis: ❑ Yes ❑ No
If yes: ❑ Hemodialysis or
❑ Peritoneal Dialysis
If no: < or > 1 year _____________
❑ Chronic, Dialysis: ❑ Yes ❑ No
If yes: ❑ Hemodialysis or
❑ Peritoneal Dialysis

❑ Kidney Stones, ❑ Operated or Passed

8. DIGESTIVE/INTESTINAL/ENDOCRINE

❑ Cirrhosis of Liver

❑ Colostomy, ❑ Still Open ❑ Closed

❑ Crohn's Disease: ❑ Operated

❑ Diabetes
❑ Type I or Juvenile:
❑ Insulin Injections ❑ Insulin Pump
❑ Other ____________________
❑ Type II
❑ Diet Controlled
❑ Oral Medications
❑ Insulin Injections
❑ Insulin Pump

❑ Hepatitis
❑ A: ❑ present ❑ recovered
❑ B: ❑ acute ❑ chronic ❑ recovered
❑ C: ❑ acute ❑ chronic ❑ recovered

❑ Pancreatitis
❑ Acute ❑ Operated
❑ Chronic

❑ Ulcerative Colitis
❑ Operated

❑ Thyroid Disorders
❑ Hypothyroid
❑ Hyperthyroid
❑ Goiter
❑ Operated

❑ Stomach Ulcer
❑ Operated

❑ GERD (Gastric Esophageal Reflux Disorder)

Employee Name: ____

VI. Medical History Information, continued

9. NEUROLOGICAL/PSYCHOLOGICAL

- ❑ Alzheimer's
- ❑ Amyotrophic Lateral Sclerosis – Lou Gehrig's Disease
- ❑ ADD or ADHD
- ❑ Bipolar Disorder
- ❑ Schizophrenia
- ❑ Psychotic Disorder
- ❑ Anxiety
- ❑ Anorexia or Bulimia
  - ❑ Active ❑ Recovered
- ❑ Attempted Suicide
- ❑ Cerebral Palsy
  - ❑ Currently under age 5?
  - ❑ Currently age 5 or over?
    - ❑ Functionally Dependent
    - ❑ Functionally Independent
- ❑ Depression
- ❑ Drug Abuse
  - ❑ Current ❑ Past
- ❑ Alcohol Abuse
  - ❑ Current ❑ Past
- ❑ Epilepsy
  - ❑ Febrile
  - ❑ Primary Generalized
- ❑ Multiple Sclerosis
  - ❑ Neurological Disability
    - ❑ Wheelchair Bound? ❑ Yes ❑ No
  - ❑ Asymptomatic/Remission
    - ❑ Wheelchair Bound? ❑ Yes ❑ No
- ❑ Paralysis
  - ❑ Quadriplegic
  - ❑ Paraplegic
  - ❑ Hemiplegic
  - ❑ Bells Palsy
  - ❑ Other
- ❑ Parkinson's
  - ❑ Controlled
  - ❑ Other ________________________
- ❑ Spina Bifida:
  - ❑ Operated ❑ Non-Operated
  - ❑ Cervical (neck)

10. MUSCULAR/SKELETAL

- ❑ Fibromyalgia
- ❑ Amputation
  - ❑ finger or toe
    - ❑ Non-Disease ❑ Disease
  - ❑ One hand or arm
    - ❑ Non-Disease ❑ Disease
  - ❑ leg or foot
    - ❑ Non-Disease ❑ Disease
  - ❑ more than one amputation
    - ❑ Non-Disease ❑ Disease
- ❑ Arthritis
  - ❑ Psoriatic
  - ❑ Rheumatoid
  - ❑ Osteo
    - ❑ use no medications
    - ❑ use OTC medications
    - ❑ use prescription medications
- ❑ Degenerative Disc/Herniated Disc
  Location ________________________
  - ❑ Operated
    - ❑ Symptomatic
    - ❑ Asymptomatic
  - ❑ Unoperated
    - ❑ Current History
    - ❑ Past History
- ❑ Fractures
  - ❑ Arm
    - ❑ Operated ❑ Unoperated
  - ❑ Leg
    - ❑ Operated ❑ Unoperated
  - ❑ Spine
    - ❑ Operated ❑ Unoperated
  - ❑ Fingers or Toes
    - ❑ Operated ❑ Unoperated
  - ❑ Skull
    - ❑ Operated ❑ Unoperated
- ❑ Other ______________________
  - ❑ Operated ❑ Unoperated
- ❑ Joint Replacement
  - ❑ Surgery Completed
  - ❑ Surgery Anticipated
- ❑ Muscular Dystrophy
- ❑ Osteoporosis

11. REPRODUCTIVE

- ❑ BPH (enlarged prostate)
  - ❑ Operated ❑ Unoperated
- ❑ Infertility
- ❑ Pregnant
  - ❑ Single Fetus
  - ❑ Multiple Fetuses
  - ❑ Past Pregnancy Complications (i.e. Gestational Diabetes, Miscarriage, Premature Birth) ________________
- ❑ Sexually Transmitted Disease(s)
  - ❑ Present ❑ History of
- ❑ Endometriosis
  - ❑ Operated ❑ Unoperated
- ❑ Polycystic Ovary
  - ❑ Operated ❑ Unoperated
- ❑ Abnormal Pap
  - ❑ Current ❑ History of
- ❑ Breast Conditions
  - ❑ Implants
    - ❑ Operated ❑ Unoperated
  - ❑ Reduction
    - ❑ Operated ❑ Unoperated
  - ❑ Reconstruction
    - ❑ Operated ❑ Unoperated
- ❑ Fibrocystic Breast Disease
- ❑ Other Reproductive ________________

12. SKIN/INTEGUMENTARY

- ❑ Psoriasis
- ❑ Acne
- ❑ Cyst
  - ❑ Operated ❑ Unoperated
- ❑ Burns
  - ❑ 1st Degree
  - ❑ 2nd Degree
  - ❑ 3rd Degree
    - ❑ Under Treatment
    - ❑ Treatment concluded
- ❑ Other ____________________________

13. Are any types of tobacco used? ❑ Yes ❑ No

14. Have you ever had or been advised to have an organ or bone marrow transplant?
❑ Yes ❑ No
If yes, please explain ________________
If yes, ❑ Pending or ❑ Completed

15. Any other medical conditions not listed above that have ever been diagnosed or treated by a health care provider?
❑ Yes ❑ No

16. Have you been advised to have surgery which has not been preformed yet? If yes, please explain ________________________
____

17. Do you take any over the counter (OTC) medications ? If yes, please list OTC medication and the reason for the OTC medication. ________________________
____

18. Have you ever been covered by Worker's Compensation? If yes, is Worker's Compensation case still open? __________
Dates covered ______________________

19. Have you ever been covered by Disability? If yes, is case still open? ______________
Dates covered ______________________

20. In the last five years have you been treated (including medication) for, diagnosed with, or sought treatment from a member of the medical profession for:
Macular degeneration, retinitis, pigmentosa, retinopathy? ❑ Yes ❑ No

VII. Explanation Section

When completing the application, please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk. Provide an explanation for each box marked in questions 1 - 12 and for each box marked “Yes” in questions 14 - 20 from the previous page. Any prescription medications that are **not** in response to the questions above - please list prescription medication and the reason for the medication. If additional space is needed, use the ***Other Information*** section below. Attach additional sheets if necessary.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Treatment Dates		# of times hospitalized for this condition?	Date of most recent inpatient stay		Medications
					From	To		From	To	
List prescripton medications not in response to the questions listed above										

VIII. Other Information (continue on a separate sheet of paper if necessary)

IX. IMPORTANT: Employee/Applicant Signature (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.

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. I further acknowledge and agree that Highmark may disclose enrollment, disenrollment summary health and/or premium billing information requested by the POR (Producer of Record) for purposes of inputting, updating and/or reviewing the same for the above identified business.

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.

Employee Signature *Date*

Print Employee Name