



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two Person*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Employee and Spouse/Domestic Partner only

I. Employee/Applicant Information

Effective Date of Coverage / /	Employer Name	Group Number	Reason for Application <input type="checkbox"/> New Enrollee
Employee Name - First	Middle Initial	Last	<input type="checkbox"/> COBRA Start Date: _____
Street Address		City	County
		State	Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled	Date of Hire / /	Hours worked per week
Job Title	Email Address (optional)		<input type="checkbox"/> Changes <input type="checkbox"/> Act 4 <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete top of next page	Birth Date			Sex F/M	Check If			Enrollment Changes		
				Mo	Dy	Yr		Dis-abled	Student Over 19	Act 4	Dependent Changes	Other Changes	Cancel/COBRA Reasons
<input type="checkbox"/> Self											<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Deceased <input type="checkbox"/> Left Employment <input type="checkbox"/> Involuntary Lay-Off <input type="checkbox"/> Other Coverage	
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*											<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*											<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*											<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	
<input type="checkbox"/> Child <input type="checkbox"/> Other*											<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Date of Above Event: _____	<input type="checkbox"/> Name Change <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage	

*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.

Employee 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.

Office Use Only. Do not write in the spaces below.
Group Number
Report Code Qualifier
Report Code Value

 Authorized Employer Signature

 Date

 Print Company Name

 Employee Signature

 Date

 Print Employee Name

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.

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

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.

V. IMPORTANT: Authorized Signatures (required)

Self - First Name	Spouse - First Name	Dependent - First Name	Health Insurance Claim Number
Last Name / Part A Effective Date / Part B Effective Date / Part D Effective Date	Last Name / Part A Effective Date / Part B Effective Date / Part D Effective Date	Last Name / Part A Effective Date / Part B Effective Date / Part D Effective Date	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

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

Name of Insurance Carrier	Policyholder Date of Birth /	Policyholder Employment Status	Relationship to Policyholder
Group Number / Effective Date / Name of Policyholder	Policyholder Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired - List Date of Retirement: / /	Policy Number	Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

IV. About Your Other Group or Non-Group Health Insurance Coverage and Medicare



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Highmark
 P.O. Box 890172
 Camp Hill, PA 17089-0172
 or
 Fax to: 888-567-5685