APPLICATION FOR NEW 2016 INDIVIDUAL/FAMILY PLAN HEALTH INSURANCE

PLEASE COMPLETE STEPS 1-6.

If you are an insurance agent/producer, please complete Steps 1-7.

STEP 1) Tell us about yourself.

STEP 2) Tell us about your household.

STEP 3) Find your county in the list below and go to the page number provided to choose your plan.

STEP 3b) Choose your plan for Conversion or HIPAA ONLY. See page 2 for more details.

STEP 4) Tell us if you have other health insurance.

STEP 5) Sign, authorize, and date your Application.

STEP 6) Send your completed Application (ALL PAGES) and payment to Highmark.

STEP 7) *If you are an insurance agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.*

To submit your application faster, please use this option to enroll:

- **By phone: 1-855-329-1766**

HIGHMARK®

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company.

WHO CAN ENROLL IN THE PLANS LISTED ON THIS APPLICATION?

You can enroll in one of these plans, regardless of your age, if:

- You want to purchase directly from Highmark and NOT through the Health Insurance Marketplace. **Plans available on this Application do not apply Federal Premium Tax Credits or Cost-Sharing Reductions.** If you are unsure if you qualify for financial help including Federal Premium Tax Credits or Cost-Sharing Reductions, please contact the Health Insurance Marketplace at www.HealthCare.gov or 1-800-318-2596.
- You are not entitled to benefits under Medicare Part A, enrolled in Medicare Part B, Medical Assistance or CHIP
- You meet eligibility guidelines listed in Step 5 of this Application
- You reside in one of the counties listed on pages 5-7 of the Application

DO YOU NEED CONVERSION OR HIPAA COVERAGE?

Are you converting from group to individual coverage because you lost your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company group coverage? You are eligible for an individual Conversion plan that covers you beginning on the date your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company group coverage ends. Depending on the coverage Effective Date you select, your first premium payment will include a prorated amount for the days remaining in the month your group coverage ended. The amount is based on the number of family members who were enrolled in your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company group plan on the date coverage was terminated. The amount of your first premium payment will also include the following full month of coverage. Your Application and first premium are due by the date noted in Step 3b of this Application on page 8.

Are you enrolling in Health Insurance Portability & Accountability Act (HIPAA) coverage because your employer group, governmental or church plan coverage ended? Please indicate the date you lost coverage in Step 3b of this Application. You must return your Application within 63 days from the date that your prior Employer group, governmental or church coverage ended. If your children are eligible for HIPAA, you can enroll them in the program without choosing HIPAA coverage for yourself.

To apply, please be sure to complete STEP 3b on page 8.

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 us at 1-855-329-1766 to request these free services. (TTY/TDD: 711)

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llámenos al 1-855-329-1766 para solicitar estos servicios gratuitos. (TTY/TDD: 711)

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，包括殘障或英語能力有限，請致電1-855-329-1766來要求這些免費服務。(TTY/TDD: 711)

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang mga akomodasyon para sa mga kapansanan o limitadong kahusayan sa wikang Ingles, mangyaring tawagan kami sa 1-855-329-1766 para hilingin ang mga libreng serbisyong ito. (TTY/TDD: 711)

Nihinaanish niizhónígo bee nihiká' adiilwołígíí binahji' ts'ídá yéego bidiilkaal, nihí naaltsoos nidahonílígíí dóó Bee Atah ídlínígíí nihił hada'díť'éhígíí niha. Bilagáana bizaad doo hazhó'ó bik'i'diitiihgo, áka'a'ayeed nínízingo, béésh bee hane'é bikáá', eí eí 1-855-329-1766, t'áá jíík'eh níka' idoowołgo áť'é. T'áájó nijéékałgo eí TTY chodayooł'ínígíí 711 nídíígis dóó bich'į' hólne' dooleeł, díí eí t'áá jíík'eh níka' idoowoł.

Highmark Blue Cross Blue Shield does 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 benefit determinations.

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

STEP 1 TELL US ABOUT YOURSELF

Complete this section if:

- You are applying for health insurance through Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company.
- You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).
- If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Provide your child's information in STEP 2 and check this box ❑.

Please note: Processing of your application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	REQUESTED EFFECTIVE DATE
				/ /

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	❑ Male ❑ Female	/ /

HOME ADDRESS	APARTMENT NUMBER

CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	APARTMENT NUMBER

CITY	STATE	ZIP CODE	COUNTY

❑ Check here if you don't have a home address. You still need to give a mailing address.

HOME PHONE NUMBER (NON-MOBILE)	WORK PHONE NUMBER	CELL PHONE NUMBER
( )	( )	( )

EMAIL ADDRESS

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	PREFERRED LANGUAGE READ (IF NOT ENGLISH)

❑ Check here if person listed in STEP 1 is applying for coverage for himself/herself ONLY.

PRIMARY CARE PHYSICIAN (REQUIRED FOR HMO)	❑ Check here if presently a patient of this physician.	PCP NUMBER (REQUIRED FOR HMO)

To find your PCP Number, please visit www.HighmarkBCBS.com and click on "Find a Doctor or RX".

1. **(REQUIRED)** If you will be covered under the plan and you are 18 years of age and older:
   Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 1 is required and must be completed or your application will be delayed.

2. Indicate how you would like to receive your member materials including Member Guide, Agreement/Endorsements, Summary of Benefits, and/or Coverage and Explanation of Benefits:
   ❑ Online - you will be emailed at the address above when available
   ❑ In the mail at the address noted above

3. ❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability. Call us at 1-855-329-1766. You can also call TTY at 711 or visit one of our Highmark Direct stores to receive assistance free of charge.

GO TO STEP 2 Household

STEP 2 TELL US ABOUT YOUR HOUSEHOLD

Tell us about everyone who is applying for coverage. Attach additional sheets of paper if needed. Eligible dependents include:

- Your spouse
- Your domestic partner
- Your children who are under age 26
- Your spouse's children who are under age 26
- Your domestic partner's children who are under age 26

The plan and deductible option you choose will apply to everyone covered by your plan.

PERSON 2

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	❑ Male ❑ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED FOR HMO)		PCP NUMBER (REQUIRED FOR HMO)
	❑ Check here if presently a patient of this physician.	

1. Does PERSON 2 live at the same address as you? ❑ Yes ❑ No
   If No, list address: _____
2. Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your application will be delayed.

3. ❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-329-1766. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

PERSON 3

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	❑ Male ❑ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED FOR HMO)		PCP NUMBER (REQUIRED FOR HMO)
	❑ Check here if presently a patient of this physician.	

1. Does PERSON 3 live at the same address as you? ❑ Yes ❑ No
   If No, list address: _____
2. Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your application will be delayed.

3. ❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-329-1766. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

PERSON 4

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	❑ Male ❑ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED FOR HMO)		PCP NUMBER (REQUIRED FOR HMO)
	❑ Check here if presently a patient of this physician.	

1. Does PERSON 4 live at the same address as you? ❑ Yes ❑ No
   If No, list address: _____
2. Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your application will be delayed.

3. ❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-329-1766. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

Applicant's Last Name	First Name

GO TO STEP 3 Plan Selection

STEP 3 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Allegheny, Beaver, Butler, Erie, Washington, Westmoreland

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Health Savings Blue PPO Embedded 2700 a Community Blue Flex Plan** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Annual Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family
- ❑ **Connect Blue EPO 5500 a Community Blue Flex Plan** - Annual Deductible: $5,500 Individual/$11,000 Family
- ❑ **Connect Blue EPO 2500 a Community Blue Flex Plan** - Annual Deductible: $2,500 Individual/$5,000 Family
- ❑ **Connect Blue EPO 750 a Community Blue Flex Plan** - Annual Deductible: $750 Individual/$1,500 Family
- ❑ **Connect Blue EPO 250 a Community Blue Flex Plan** - Annual Deductible: $250 Individual/$500 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care Blue PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Bedford, Cambria, Huntington, Somerset, Venango

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Annual Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care Blue PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

GO TO STEP 4 Other Health Insurance

Please complete the form below.

Policyholder Name (First, Middle, Last): _____

Phone Number: ( ) _____ Zip Code: _____ Social Security Number (*last 4 digits*): _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____ Group Number (*see above; listed above plan selection*): _____

If you plan to fax your application, mail in this page with your first month payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 3 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Armstrong, Crawford, Indiana, Lawrence, McKean

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Flex Blue PPO 1200 PA Mtns HealthCare Region a Community Blue Plan -** Annual Deductible: $1,200 Individual/$2,400 Family
- ❑ **Health Savings Blue PPO Embedded 2700 a Community Blue Flex Plan** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Annual Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care Blue PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Fayette, Greene, Mercer, Warren

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Health Savings Blue PPO Embedded 2700 a Community Blue Flex Plan** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

GO TO STEP 4 Other Health Insurance

Please complete the form below.

Policyholder Name (First, Middle, Last): _____

Phone Number: ( ) _____ Zip Code: _____ Social Security Number (*last 4 digits*): _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____ Group Number (*see above; listed above plan selection*): _____

If you plan to fax your application, mail in this page with your first month payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 3 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Blair, Cameron, Clarion, Forest, Jefferson, Potter

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Flex Blue PPO 1200 PA Mtns Healthcare Region a Community Blue Plan** - Annual Deductible: $1,200 Individual/$2,400 Family
- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Annual Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care Blue PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Centre*, Clearfield, Elk, Jefferson

*Note: You must reside in one of the following zip codes in Centre County to enroll in one of these plans - 16666, 16686, 16829, 16845, 16859, 16860, 16874, 16877.

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ❑ **Flex Blue PPO 1200 Penn Highlands Region a Community Blue Plan -** Annual Deductible: $1,200 Individual/$2,400 Family
- ❑ **Major Events Blue PPO 6850 a Community Blue Plan** - Annual Deductible: $6,850 Individual/$13,700 Family

  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]
- ❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan** - Annual Deductible: $6,000 Individual/$12,000 Family

Highmark Choice Company Group Number: 058000-00

- ❑ **Care Guide Blue HMO 500** - Annual Deductible: $500 Individual/$1,000 Family

Highmark Health Insurance Company Group Number: 036000-00

- ❑ **Comprehensive Care Blue PPO 1500** - Annual Deductible: $1,500 Individual/$3,000 Family
- ❑ **Comprehensive Care Flex Blue PPO 500** - Annual Deductible: $500 Individual/$1,000 Family
- ❑ **Health Savings Blue PPO Embedded 4500** - Annual Deductible: $4,500 Individual/$9,000 Family
- ❑ **Health Savings Blue PPO Embedded 2700** - Annual Deductible: $2,700 Individual/$5,400 Family
- ❑ **Health Savings Blue PPO 1400** - Annual Deductible: $1,400 Individual/$2,800 Family
- ❑ **Shared Cost Blue PPO 6000** - Annual Deductible: $6,000 Individual/$12,000 Family

GO TO STEP 4 Other Health Insurance

Please complete the form below.

Policyholder Name (First, Middle, Last): _____

Phone Number: ( ) _____ Zip Code: _____ Social Security Number (*last 4 digits*): _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____ Group Number (*see above; listed above plan selection*): _____

If you plan to fax your application, mail in this page with your first month payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 3b CHOOSE YOUR PLAN - CONVERSION OR HIPAA ONLY

Choose only one plan and deductible option. Place an 'X' in the correct check box.
The plan and deductible option you choose will apply to everyone covered by your plan.

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Blue Cross Blue Shield** group plan ended OR

You are applying for a Health Insurance Portability & Accountability Act (HIPAA) plan to cover you from the date your last employer coverage ended.

❑ **Shared Cost Blue PPO 6000 a Community Blue Flex Plan**
$6,000 Annual Individual Deductible/$12,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

Highmark Blue Cross Blue Shield
Group Number: 037000-00

APPLICATION DUE DATE: _____ FIRST PREMIUM AMOUNT DUE: _____

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: _____ Effective to: _____

❑ HIPAA Policy - Effective from: _____ Effective to: _____

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Health Insurance Company or Highmark Coverage Advantage** group policy ended.

❑ **Shared Cost Blue PPO 6000**
$6,000 Annual Individual Deductible/$12,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

Highmark Health Insurance Company
Group Number: 036000-00

APPLICATION DUE DATE: _____ FIRST PREMIUM AMOUNT DUE: _____

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: _____ Effective to: _____

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Choice Company** group ended.

❑ **Care Guide Blue HMO 500**
$500 Annual Individual Deductible/$1,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

Highmark Choice Company
Group Number: 058000-00

APPLICATION DUE DATE: _____ FIRST PREMIUM AMOUNT DUE: _____

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: _____ Effective to: _____

GO TO STEP 4 Other Health Insurance

Please complete the form below.

Policyholder Name (First, Middle, Last): _____

Phone Number: ( ) _____ Zip Code: _____ Social Security Number (*last 4 digits*): _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____ Group Number (*see above; listed above plan selection*): _____

If you plan to fax your application, mail in this page with your first month payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 4 TELL US ABOUT OTHER HEALTH INSURANCE INFORMATION

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ❑ Yes ❑ No
2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B? ❑ Yes ❑ No
3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Highmark policy. ❑ Yes ❑ No

If you answered "Yes" to any question above, complete question 4. If you answered "No," skip question 4 and go to the next section.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

Name of Insurance Carrier: _____ Group Number: _____

Name of Policy Holder: _____ Effective Date: _____

Policy Number: _____ Relationship to Applicant: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employment Status: _____

ANSWER QUESTIONS 5-9 ONLY IF YOU ARE APPLYING FOR HIPAA COVERAGE.

5. If your most recent coverage offered you "COBRA" or similar continuation of coverage benefits required by the state, did you elect that coverage? ❑ Yes ❑ No If YES, have you used up all your benefits under that coverage? ..... ❑ Yes ❑ No
6. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months? * ❑ Yes ❑ No

   * Here's how to find out if you have the required 18 months of prior creditable coverage: Count periods of creditable coverage that you had before any breaks in coverage. Count them only if the break in coverage was less than 63 days. Do not count days during a waiting period when you had no coverage. Do not count days in a waiting period to determine if you had a break in coverage.

7. Did your most recent health care coverage end within the last 63 days? ..... ❑ Yes ❑ No
8. Did your most recent health care coverage terminate because you did not pay your premium? This includes contributions or fraud. ❑ Yes ❑ No
9. Are you attaching a copy of your "Certificate of Prior Creditable Coverage" form? ..... ❑ Yes ❑ No

   If you answered "No" to question 9 above, you can still prove that you had prior coverage in one of the following ways:

   a) Send us your signed written statement about your last coverage. Include names of the plans that covered you in the last 18 months. Include the beginning and end dates of coverage. Attach copies of papers proving that you had coverage during those times. This can be a copy of an identification card or an explanation of benefits. It can also be premium invoices or pay stubs proving that you paid for health coverage. You must also cooperate with us to prove that you had coverage.

   - OR -

   b) Complete and send us a HIPAA Prior Coverage Disclosure and Authorization Form instead of a written statement. You can get this form by calling Customer Service at 1-800-544-6679. You can also call us to establish that you had coverage. Give us as much information as you can. Sign the form to let us contact your prior plans to prove that you had coverage.

Applicant's Last Name	First Name

GO TO STEP 5 Authorization

STEP 5 SIGN, AUTHORIZE AND DATE APPLICATION

NOTIFICATION AND AUTHORIZATION

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

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. A copy of Highmark's Notice of Privacy Practices is available on the Highmark Website or from the Highmark Privacy Office.

I/we understand that the Agreement is available only to residents of the geographic area in which the product for which this Application is completed is available and that this Application is subject to the provisions of the Agreement.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark if any information I supplied on this Application changes. I can call 1-800-544-6679 to report any changes.

EFFECTIVE DATE OF COVERAGE

I/we understand/agree that, subject to the conditions of enrollment on this Application, coverage will be effective for individuals listed on this Application following receipt of a completed Application and payment of the first premium in full:

If you are applying during:

Open Enrollment Period:

a) On January 1, 2016 if the Application is received on or before December 15, 2015.
   -or-
b) On February 1, 2016 if the Application is received from December 16, 2015 through January 15, 2016.
   -or-
c) On March 1, 2016 if the Application is received from January 16, 2016 through January 31, 2016.

OR

Special Enrollment Period/Limited Open Enrollment Period:

Coverage will be effective based on the applicable laws defined for each Special Enrollment Period or Limited Open Enrollment Period.

OR

In the case of HIPAA coverage or a Conversion policy, on the Effective Date indicated on this Application.

PAYMENT AND BILLING INFORMATION

This Agreement renews on an annual basis. If the first payment is not made with this application, the first premium payment is due by the due date printed on your first invoice. Failure to pay before this due date will result in your application being cancelled. You can pay your premium monthly in advance to Highmark. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your on-going monthly premium payments are not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Make your check or money order payable to Highmark for your first full premium due. See rates for details. Please include the correct Group Number (included in Step 3 on pages 5-8) on your check or money order.

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

I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of such contract.

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.

Applicant's Signature _____ Date _____

Spouse/Domestic Partner/Parent's Signature _____ Date _____

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18, and applying for a policy that only covers yourself, your parent or guardian must sign.

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE APPLICANT.

GO TO STEP 6 Submission

STEP 6 SEND YOUR COMPLETED APPLICATION AND PAYMENT TO HIGHMARK

Send in your completed Application and payment to Highmark by one of the following methods. **PLEASE RETURN ALL PAGES OF THE APPLICATION.** If a specific section does not apply to you, please mark as 'N/A'.

U.S. MAIL:

Include your completed, signed Application along with your first premium payment to:
Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

FAX:

Fax your completed, signed Application to 1-866-224-5403 -- *and* -- mail your first premium payment along with a copy of Step 3 (or 3b) with your plan selection to:
Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

DROP YOUR APPLICATION AND PAYMENT OFF IN PERSON AT YOUR LOCAL HIGHMARK DIRECT STORE:

For locations, please visit www.HighmarkDirect.com

PLEASE NOTE:

This Agreement renews on an annual basis. If the first payment is not made with this application, the first premium payment is due by the due date printed on your first invoice. Failure to pay before this due date will result in your application being cancelled. You can also pay your premium monthly in advance to Highmark. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your on-going monthly premium payments are not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your first premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

NEED HELP?

- **Call with questions or to enroll over the phone:** 1-855-329-1766
- **Enroll online:** www.DiscoverHighmark.com/individuals-families/
- **For in-person visit:** Your local Highmark Direct store (www.HighmarkDirect.com)
- **If you work with an insurance agent/producer:** Please call or visit him/her directly

Please note: Processing of your application may be delayed if this form is NOT completed in its entirety. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to your situation, please mark as 'N/A'.

STEP 7 - FOR PRODUCER USE ONLY

PRODUCER'S CERTIFICATE

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-866-602-1248.

If this section is not fully completed, we will not pay a commission.

Blue Cross Blue Shield Agency No. | | | | | | | |

Producer No. | | | | | | | |

Agency Name _____

Producer's Name _____

Producer's Signature _____
LAST *FIRST* *MI*

Business Phone ( ) _____
Area Code

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about his/her dependents applying for this coverage? ❑ No ❑ Yes

_____
Producer Signature Date

_____
Agency

2. Have you provided the applicant with all relevant marketing materials? ❑ No ❑ Yes

3. Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)? ❑ No ❑ Yes

4. Is this applicant a current customer of Highmark? ❑ No ❑ Yes

5. Have you retained a signed copy of this Application for your records? ❑ No ❑ Yes

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark's rights or requirements.

Highmark Inc., d/b/a
Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company. Highmark Blue Cross Blue Shield, Highmark Health Insurance Company and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.

INTERNAL USE ONLY

Blue Cross Blue Shield Agency No. | | | | | | | |

Producer No. | | | | | | | |