HIGHMARK® HEALTH INSURANCE COMPANY

ENROLLMENT/WAIVER FORM

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

❑ ENROLLING
❑ WAIVING

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No.

Address | Email Address

City | State | Zip | Home Phone | Work Phone

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

Employment Status
❑ Active ❑ COBRA ❑ Disabled

Date of Full-Time Hire
Mo Day Yr

Hours Worked Per Week

❑ COBRA
Start Date _____
End Date _____

COBRA REASON:
❑ Deceased ❑ Involuntary Lay-Off Date of Event _____
❑ Left Employment ❑ Other _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

Covered Dependents and Relationship	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Sex	Height	Weight	Dependent Status If Over Age 26	Med	Vis	Den
Self			/ /	❑ M ❑ F						
❑ Spouse ❑ Dom. Part.*			/ /	❑ M ❑ F						
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			

*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 and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship: ❑ Other: _____

III WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s)) EMPLOYEE AND EMPLOYER MUST SIGN BELOW

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

REASON FOR DECLINING MEDICAL COVERAGE:
❑ Insured under spouse's contract with the following insurance carrier:
_____
❑ Other: _____

VISION

I HEREBY DECLINE VISION COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

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 | Employer Signature | Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

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.

BOTH EMPLOYEE AND EMPLOYER SIGNATURES ARE REQUIRED FOR WAIVERS

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 / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status
			❑ Active ❑ Retired - List Date of Retirement: / /

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

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective 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: EMPLOYEE AND EMPLOYER MUST SIGN BELOW

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

For New Business:
Highmark
Small Group Sales
120 Fifth Avenue Suite P2504
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