



An Independent Licensee of the Blue Cross and Blue Shield Association

## HOW TO COMPLETE YOUR HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Following are instructions for completing the Highmark Blue Shield Enrollment Application.

All information must be completed as indicated.

### EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

- 1) Employer Name
- 2) Employee First Name, skip a space, Last Name. (no middle initial)
- 3) Employee Street Address
- 4) City
- 5) State
- 6) Zip Code
- 7) Employee Social Security Number
- 8) Effective Date of Coverage
- 9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee
- 10) Employee Daytime Phone Number (including area code)
- 11) Employee Evening Phone Number (including area code)
- 12) Employee Date of Hire
- 13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

Items **14** through **18** ask for important information about yourself and each eligible member of your family (**14** yourself, **15** your spouse/ domestic partner, **16-18** your dependents). Please complete all requested information. We require this information to properly enroll you and your eligible dependents. If relationship is "other", please indicate the dependent's relationship to you according to the codes provided on the application.

- **First Name/Last Name**—Complete the first and last name for each eligible person listed. Skip a space between first and last name. Do not use a middle initial.
- **Social Security Number**—Please include the Social Security Number of each person.
- **Do you have other insurance?**—If you or a family member have other medical insurance, including Medicare, respond "Yes". If not, you must respond "no".
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over 19 and/or Disabled**—If your dependent is over the age of 19 and a full time student or a disabled dependent of any age, please check (✓) the appropriate column by that dependent's name.
- 19) If you checked "Yes" for **Other Insurance**, this information needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested.
- 20) Should be completed by your account administrator.
- 21) You must sign and date the form where indicated.
- 22) Do not complete any of the information below the Employee Signature and Date.

**Once the form is completed, retain the last copy for your records.**

# HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.

1) Employer Name \_\_\_\_\_

2) Employee First Name / Last Name *(Please Print)* \_\_\_\_\_

3) Street Address \_\_\_\_\_ 4) City \_\_\_\_\_ 5) State \_\_\_\_\_ 6) Zip \_\_\_\_\_

7) Social Security Number \_\_\_\_\_

8) Effective Date of Coverage  
 Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

9) Employee Status  
 Active  Hourly  
 Retired  Salary

10) Employee Phone #—Day (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

11) Employee Phone #—Evening (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

12) Hire Date  
 Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Complete items 14 through 19 where applicable. List eligible participants (if you have additional dependents, attach separate sheet)

Complete Where Applicable	First Name	Please Print Middle Initial	Last Name	Social Security Number	Do you have other insurance?	Birth Date		Sex F/M	Check if Student Over 19 Disabled
						Mo	Dy		
14) Self					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19				
15) <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19				
16) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19				
17) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19				
18) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19				

\* "domestic partner" or "other" applies, complete using one of the following codes: —Grandson, Nephew, Brother (11), —Granddaughter, Niece, Sister (12), —Stepson (13), —Stepdaughter (14) —Male Domestic Partner (17) —Female Domestic Partner (18)

19) Please check one if applicable (If additional space is required, attach a separate sheet). If you  your spouse/domestic partner  or dependent(s)  are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Is Coverage Still in Effect?  Yes  No

ID # or HIC #: \_\_\_\_\_ If NO, Cancel Date: \_\_\_\_\_

If you have Medicare, check if you have:  Part A - Part A Effective Date: \_\_\_\_\_  Part B - Part B Effective Date: \_\_\_\_\_

I certify that the information provided on this form is true to the best of my knowledge. 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 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 understand that this form enrolls those eligible persons listed above in the Medical Plan 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.

20) \_\_\_\_\_ Date \_\_\_\_\_  
 Authorized Employer Signature

21) \_\_\_\_\_ Date \_\_\_\_\_  
 Employee Signature

22) To be completed by Account/Administrator only

Group Number \_\_\_\_\_ Payroll Number \_\_\_\_\_ Clock Number \_\_\_\_\_



P.O. Box 890172  
 Camp Hill, PA 17089

13) Check Type of Coverage MEDICAL VISION DRUG PRODUCT NAME

Employee Only

Insured & Spouse/Domestic Partner

Family

Parent & Child

Parent & Children

PLAN USE ONLY	PR Plan	FA Plan	MM Plan	Dental			Vision			Drug			
				A	B	C	D	E	A	B	C	D	E
PR Plan Area													
FA Plan Area													
MM Plan Area													
Dental Plan Area													
Vision Plan Area													
Drug Plan Area													

# HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.

1) Employer Name		4) City		5) State		6) Zip	
2) Employee First Name / Last Name <i>(Please Print)</i>							
3) Street Address							
7) Social Security Number		8) Effective Date of Coverage		9) Employee Status			
		Mo Day		<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salary			
10) Employee Phone #—Day		11) Employee Phone #—Evening		12) Hire Date			
				Mo Day		Year	

Complete items 14 through 19 where applicable. List eligible participants (if you have additional dependents, attach separate sheet)

Complete Where Applicable	First Name	Please Print Middle Initial	Last Name	Social Security Number	Do you have other insurance?	Birth Date		Sex F/M	Check if Student Over 19	Dis-abled
						Mo	Dy			
14) Self					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
15) <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
16) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
17) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
18) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					

\*If "domestic partner" or "other" applies, complete using one of the following codes: —Grandson, Nephew, Brother (11), —Granddaughter, Niece, Sister (12), —Stepson (13), —Stepdaughter (14) —Male Domestic Partner (17) —Female Domestic Partner (18)

<p>19) Please check one if applicable (if additional space is required, attach a separate sheet). If you <input type="checkbox"/> your spouse/domestic partner <input type="checkbox"/> or dependent(s) <input type="checkbox"/> are enrolled in another Program or Medicare, please give the following information:</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ID # or HIC #: _____ If NO, Cancel Date: _____</p> <p>If you have Medicare, check if you have: <input type="checkbox"/> Part A - Part A Effective Date: _____ <input type="checkbox"/> Part B - Part B Effective Date: _____</p>	<p>Please check one if applicable (if additional space is required, attach a separate sheet). If you <input type="checkbox"/> your spouse/domestic partner <input type="checkbox"/> or dependent(s) <input type="checkbox"/> are enrolled in another Program or Medicare, please give the following information:</p> <p>Name of Insurance Carrier: _____ Effective Date: _____</p> <p>Name of Insured: _____ Is Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ID # or HIC #: _____ If NO, Cancel Date: _____</p> <p>If you have Medicare, check if you have: <input type="checkbox"/> Part A - Part A Effective Date: _____ <input type="checkbox"/> Part B - Part B Effective Date: _____</p>
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I certify that the information provided on this form is true to the best of my knowledge. 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 material 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 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 understand that this form enrolls those eligible persons listed above in the Medical Plan 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.

20) \_\_\_\_\_ Date

Authorized Employer Signature

21) \_\_\_\_\_ Date

Employee Signature

To be completed by Account/Administrator only

22) Group Number \_\_\_\_\_ Payroll Number \_\_\_\_\_ Check Number \_\_\_\_\_



P.O. Box 890172  
Camp Hill, PA 17089

13) Check Type of Coverage: MEDICAL  VISION  DRUG  PRODUCT NAME \_\_\_\_\_

Employee Only   
Insured & Spouse/Domestic Partner   
Family   
Parent & Child   
Parent & Children

# HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.

1) Employer Name		4) City		5) State		6) Zip	
2) Employee First Name / Last Name <i>(Please Print)</i>							
3) Street Address							
7) Social Security Number		8) Effective Date of Coverage		9) Employee Status			
		Mo Day		<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salary			
10) Employee Phone #—Day		11) Employee Phone #—Evening		12) Hire Date			
				Mo Day		Year	

Complete items 14 through 19 where applicable. List eligible participants (if you have additional dependents, attach separate sheet)

Complete Where Applicable	First Name	Please Print Middle Initial	Last Name	Social Security Number	Do you have other insurance?	Birth Date		Sex F/M	Check if Student Over 19	Dis-abled
						Mo	Dy			
14) Self					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
15) <input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
16) <input type="checkbox"/> Child <input type="checkbox"/> Other*					<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #19					
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22) Group Number \_\_\_\_\_ Payroll Number \_\_\_\_\_ Check Number \_\_\_\_\_



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13) Check Type of Coverage: MEDICAL  VISION  DRUG  PRODUCT NAME \_\_\_\_\_

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20) \_\_\_\_\_ Date

Authorized Employer Signature

21) \_\_\_\_\_ Date

Employee Signature

To be completed by Account/Administrator only

22) Group Number \_\_\_\_\_ Payroll Number \_\_\_\_\_ Check Number \_\_\_\_\_



P.O. Box 890172  
Camp Hill, PA 17089

13) Check Type of Coverage MEDICAL VISION DRUG PRODUCT NAME

Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured & Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent & Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>