



# Enrollment Application/Change Form for Group Coverage

**Group Administrator** Must complete all information before enrollment will be processed. Please print CLEARLY using blue or black ink or type in information to avoid delay.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| Type of Transaction <input type="checkbox"/> Add<br><input type="checkbox"/> Transfer <input type="checkbox"/> Change <input type="checkbox"/> Cancel |  | Reason: If you are making changes, please check the appropriate box and complete "Section 1. Applicant Information." If the change refers to a dependent, please also complete "Section 2. Dependent Information." |  |   |  |
| <input type="checkbox"/> Open Enrollment<br><input type="checkbox"/> Rehire/Reinstatement (mm/dd/yyyy)<br>Date ____ / ____ / ____                     |  | <input type="checkbox"/> COBRA (mm/dd/yyyy)<br>Begin Date ____ / ____ / ____<br>End Date ____ / ____ / ____  |  | <input type="checkbox"/> New Address<br><input type="checkbox"/> Other _____  |  |
|   |  | <input type="checkbox"/> Add Dependent/Spouse<br><input type="checkbox"/> Delete Dependent/Spouse<br><input type="checkbox"/> Other _____  |  | Date of Event (mm/dd/yyyy)<br>____ / ____ / ____<br>Type of Event<br>_____<br>(e.g., Marriage, Newborn, Adoption, Divorce ) |  |
| Company Name  |  | Vision Group Number  |  | Dental Group Number   |  |
| Company Number  |  | Medical Group Number   |  | Department Number   |  |
|   |  | Date Hired (mm/dd/yyyy) ____ / ____ / ____   |  | Effective Date (mm/dd/yyyy) ____ / ____ / ____  |  |

**Medical Coverage**

|  |  |   |   |
|--|--|---|---|
| <b>First Priority Life®</b><br><input type="checkbox"/> BlueCare® Traditional<br><input type="checkbox"/> BlueCare PPO<br><input type="checkbox"/> BlueCare QHD PPO<br><input type="checkbox"/> BlueCare Custom PPO<br><input type="checkbox"/> BlueCare EPO<br><input type="checkbox"/> BlueCare QHD Custom PPO<br><input type="checkbox"/> AffordaBlue <sup>SM</sup> | <b>First Priority Health®</b><br><input type="checkbox"/> BlueCare HMO<br><input type="checkbox"/> BlueCare HMO Plus<br>Signature required in the Statement of Understanding of Financial Responsibility on back.<br> | <b>Blue Cross of Northeastern Pennsylvania Highmark Blue Shield</b><br><input type="checkbox"/> BlueCare Senior<br>This coverage does not duplicate Medicare benefits and is not a supplement to Medicare.<br> | <b>Other Coverage</b><br><input type="checkbox"/> Vision<br><input type="checkbox"/> Dental<br>Vision and dental benefits are provided by an independent and/or separate company. |
|--|--|---|---|

**Section 1. Applicant Information** Must complete all information before enrollment will be processed. Form will be returned if not complete.

|   |  |   |  |                        |  |
|---|--|---|--|------------------------|--|
| Gender<br><input type="checkbox"/> M <input type="checkbox"/> F   | Marital Status<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Widowed | Social Security Number  | Date of Birth  | Primary Phone Number   | Alternate Phone Number   |
| Are you the Employee?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                     |  | If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a primary care physician (PCP) |  |                        |  |
|   |  | PCP or NPI (Office Number)  | Location/City  | Primary Care Physician | Current Patient?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Last Name  | First Name  | Middle Initial   | Email Address          |  |
| Current Address (Provide information below)   |  |   | Different Mailing Address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," all communications will be mailed to this address.) |                        |  |
| Street Number   | Street Name  |   | Street Number  | Street Name            |  |
| City  |  | State   | Zip  | City                   |  |
| County  |  | Country   |  | Country                |  |

Do you have any other health insurance that will be in effect at the same time as this coverage?  Yes  No (If "Yes," please complete Section 3, "Other Health insurance Information.") (Applicant)

**Section 2. Dependent Information** Please list all family members to be covered. For changes, check "Add" or "Delete." Attach additional sheets, if necessary.

| Add                      | Delete                   | Social Security Number | Gender | Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yyyy) | Medical                  | Dental                   | Vision                   | If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP. |                        |          | Current Patient          |
|--------------------------|--------------------------|------------------------|--------|-----------|------------|----------------|----------------------------|--------------------------|--------------------------|--------------------------|---|------------------------|----------|--------------------------|
|                          |                          |                        |        |           |            |                |                            |                          |                          |                          | PCP or NPI  | Primary Care Physician | Location |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Spouse                 |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |                        |        |           |            |                |                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |                        |          | <input type="checkbox"/> |

**Section 2. Dependent Information (Continued)**

**2a.** Is the address for any dependent(s) different from your residence address?  Yes  No (If "Yes," please complete the below section.)

|                          |               |             |      |       |     |        |
|--------------------------|---------------|-------------|------|-------|-----|--------|
| If "Yes," Dependent Name | Street Number | Street Name | City | State | Zip | County |
|--------------------------|---------------|-------------|------|-------|-----|--------|

**2b.** Do any dependents have a custodial guardian who is responsible for their care?  Yes\*  No (If "Yes," please complete the below section.)

|                                |               |             |             |       |     |        |
|--------------------------------|---------------|-------------|-------------|-------|-----|--------|
| If "Yes," Dependent(s) Name(s) | Dependent 1   | Dependent 2 | Dependent 3 |       |     |        |
| Responsible Guardian Name      | Street Number | Street Name | City        | State | Zip | County |

**2c.** Do any dependents have other health insurance coverage?  Yes  No (If "Yes," please complete the below section.)

|             |                        |                         |             |                        |                         |
|-------------|------------------------|-------------------------|-------------|------------------------|-------------------------|
| Dependent 1 | Insurance Company Name | Insurance Policy Number | Dependent 2 | Insurance Company Name | Insurance Policy Number |
|-------------|------------------------|-------------------------|-------------|------------------------|-------------------------|

**2d.** Do any dependents have Medicare coverage?  Yes  No (If "Yes," please complete the below section and provide a copy of the Medicare card(s).)

|                      |                     |   |  |   |  |
|----------------------|---------------------|---|--|---|--|
| Dependent(s) Name(s) | Medicare HIC Number | Medicare Part A<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Effective Date<br>(mm/dd/yyyy) _____ / _____ / _____ | Medicare Part B<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Effective Date<br>(mm/dd/yyyy) _____ / _____ / _____ |
|----------------------|---------------------|---|--|---|--|

**2e.** Is there someone else who is financially responsible for any dependents?  Yes\*  No (If "Yes," please complete the below section.)

|                                |               |             |             |       |     |        |
|--------------------------------|---------------|-------------|-------------|-------|-----|--------|
| If "Yes," Dependent(s) Name(s) | Dependent 1   | Dependent 2 | Dependent 3 |       |     |        |
| Responsible Party Name         | Street Number | Street Name | City        | State | Zip | County |

**2f.** Are any dependent children over age 26 disabled?  Yes  No (If "Yes," please complete Disabled Dependent Application, which you can get from your group administrator, or from our website, www.bcnepa.com.)

**2g.** Are any listed dependents over the dependent age and continuing as full-time students?  Yes  No (If "Yes," please complete for each student and verify with employer, if required.)

|                |  |                |  |
|----------------|--|----------------|--|
| Dependent Name | Expected Date of Graduation (mm/dd/yyyy) _____ / _____ / _____ | Dependent Name | Expected Date of Graduation (mm/dd/yyyy) _____ / _____ / _____ |
| Name of School |  | Name of School |  |

**Section 3. Other Health Insurance Information (Applicant)**

|  |   |   |
|--|---|---|
| Policy Holder Name   | Insurance Company Name  |   |
| Policy ID Number   | Effective Date (mm/dd/yyyy) _____ / _____ / _____                 | Termination Date (mm/dd/yyyy) _____ / _____ / _____                         |
| Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," please complete the below information.) |   |   |
| Medicare HIC Number  | Please provide a copy of your Medicare card with this application |   |
| Medicare Part A<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Effective Date (mm/dd/yyyy) _____ / _____ / _____                 | Medicare Part B<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |   | Effective Date (mm/dd/yyyy) _____ / _____ / _____                           |

**Section 5. Conditions of Enrollment**

Please sign this section of the form. The form will not be processed without your signature.

I hereby apply for enrollment as checked hereon, made available to me through the groups with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and group literature indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents, listed above, to enroll them in a Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/First Priority Health/First Priority Life Insurance Company\* health care plan. I authorize the Social Security Administration to furnish Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/First Priority Health/First Priority Life Insurance Company medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. If enrolled in a First Priority Health product, I understand that treatment rendered by a provider in the First Priority Health network will be paid at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the First Priority Health network and I will be responsible for the applicable deductible and coinsurance. I understand that if I directly access care from a nonparticipating provider, I will be solely responsible for all costs incurred.

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.

**Section 4. Ethnic Background (Optional)**

This information will not be used in considering your eligibility for benefits. No applicant will be excluded from coverage on the basis of race, color, creed, political beliefs, national origin, religion, age, gender or disability.

| Make one selection for each category:                                       |            | Ethnicity       |                     |         | Race Check all that apply |                           |       |                                   |   |       | Language          |         |         |             |         |
|---|------------|-----------------|---------------------|---------|---------------------------|---------------------------|-------|-----------------------------------|---|-------|-------------------|---------|---------|-------------|---------|
| Last Name   | First Name | Hispanic/Latino | Not Hispanic/Latino | Decline | White                     | Black or African American | Asian | American Indian or Alaskan Native | Native Hawaiian or Other Pacific Islander | Other | Two or more races | Decline | English | Non-English | Decline |
| Complete this section for each person who will be covered under this policy |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |
| Applicant   |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |
| Spouse  |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |
| Dependent   |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |
| Dependent   |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |
| Dependent   |            |                 |                     |         |                           |                           |       |                                   |   |       |                   |         |         |             |         |

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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.

**Group Administrator Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(applies to all changes)

**Section 6. Statement of Understanding of Financial Responsibility for BlueCare HMO Plus**

I understand that treatment rendered by a provider in the First Priority Health (FPH) provider network will be paid at the highest level of benefits. I also understand that if there is no provider in the FPH network that can perform the service, and the service is medically necessary and appropriate, I can request prior authorization to use a BlueCard® or non-participating provider and receive care at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the FPH network and I will be responsible for the applicable deductible and coinsurance. I understand that my plan does not provide coverage for benefits received from a non-participating provider without prior approval from FPH. I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

For Administration Use Only

\* A copy of a power of attorney or court-initiated document must be attached to this form in order for the custodial parent or responsible person to be applied.