INSTRUCTIONS FOR COMPLETING YOUR ENROLLMENT/WAIVER APPLICATION AND CHANGE FORM

HIGHMARK® HEALTH INSURANCE COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

The descriptions below should be used when completing applicable sections of your Enrollment/Waiver Application and Change Form.

In the top right hand corner please list the Product Name under which you are enrolling. Then indicate the **Type of Coverage** that you have selected for you and your eligible dependents (e.g. employee only, two person, etc.)

Employee/Applicant Information (Section I): This section must always be completed even if your coverage has not changed.

- **Effective Date of Coverage –** The effective date of new coverage or, in the event of a change in existing coverage, the effective date of the change.
- **Group Number –** To be completed only if the reason for the application is COBRA, dependent status changes or addition of an Act 4 eligible dependent (i.e. qualified dependent up to Age 30.)

Covered Dependent Enrollment/Change Information (Section II): This section requires important information about yourself and each eligible member of your family. If relationship is "Domestic Partner" or "Other", please indicate the dependent's relationship to the employee using the codes provided on the application.

Do you have other insurance? – If you or your family members have other medical insurance, including Medicare, respond "yes." If not, you ***must*** respond "no."

- **Check If Disabled, Student over 19 or Act 4** (dependents up to age 30) – If your dependent is a full time student (age 19 or over), an eligible disabled dependent (any age) or entitled to enroll for coverage under Act 4 (qualified dependent up to age 30), please check the appropriate column by that dependent's name. Act 4 eligibility is at the discretion of the employer.
- **Dependent Changes –** If adding or terminating a dependent, check the appropriate box. Please be sure to include the date of the event leading to this change.
- **Other Changes –** This column should be used to indicate changes in either your coverage and/or that of your dependents. Please check the appropriate box and include the date of the event leading to this change.
- **Cancel/COBRA Reasons –** When you and/or your dependents enroll in COBRA, the reason must be indicated.
- **Additional Comments –** If additional space is needed to describe any changes, this can be documented in Section VIII.

Waiver Information (Section III): This section must be signed and indicate the reason why you are waiving group coverage for yourself and/or your dependents.

About Your Other Group or Non-Group Health Insurance Coverage and Medicare (Section IV): If you checked "yes" to the question "Do you have other insurance?" in Section II, then you must complete this section by identifying all other coverages each enrollee has.

Authorized Signature's (Required) (Section V): This section must be completed in all cases. Your signature authorizes the enrollment of you and your dependents under the coverage selected. Both your signature and your employer's signatures are required.

Reminder: In order for your request to be processed, you must complete each of the Sections indicated below:

Initial Enrollment: Complete Sections I, II, IV and V

Waiving Coverage: Complete Sections I and III

Changing Existing Coverage: Complete Sections I, II, IV and V

Changing Existing Coverage and Adding Dependent(s): Complete Sections I, II, IV and V

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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	❑	❑	❑
Two Person*	❑	❑	❑
Family	❑	❑	❑
Parent & Child	❑	❑	❑
Parent & Children	❑	❑	❑

*Employee and Spouse/Domestic Partner only

I. Employee/Applicant Information

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

***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.

STOP HERE IF DECLINING COVERAGE

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 Policyholder

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

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

Self - *First Name*	*Last Name*	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /

Spouse - *First Name*	*Last Name*	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /

Dependent - *First Name*	*Last Name*	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /

Health Insurance Claim Number	Why are you eligible for Medicare? ❑ Age ❑ Disability ❑ End Stage Renal Disease	Do you have a Medicare Supplement or other coverage that complements Medicare? ❑ Yes ❑ No

V. IMPORTANT: Authorized Signatures (required)

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 Name _____

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or

Fax to: 888-567-5685

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