



**SUPPLEMENTAL INFORMATION  
FOR DEPENDENT ENROLLMENT**

This form must be completed if you answered "yes" to any of the questions in "Section 2. Dependent Information" of the "Enrollment Application/Change Form." Please complete only the sections that pertain to your covered dependents and attach to your completed "Enrollment Application/Change Form." Please be sure to sign the back of this form.

Applicant last name:  Mr.  Mrs.  Miss  Ms.  Sr.  Jr. First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Applicant Social Security Number: \_\_\_\_\_

**Is the address for dependents different from the primary residence address?**  Yes  No If yes: \_\_\_\_\_

Dependent 1 Last name:  Sr.  Jr. Middle name: \_\_\_\_\_ First name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Residential address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Dependent 2 Last name:  Sr.  Jr. Middle name: \_\_\_\_\_ First name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Residential address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Dependent 3 Last name:  Sr.  Jr. Middle name: \_\_\_\_\_ First name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Residential address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Dependent 4 Last name:  Sr.  Jr. Middle name: \_\_\_\_\_ First name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Residential address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

**Do any dependents have other group health insurance?**  Yes  No If yes: \_\_\_\_\_  
Dependent name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date of birth: (mm/dd/yyyy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insurance company name: \_\_\_\_\_ Insurance policy ID #: \_\_\_\_\_

Insurance company address: \_\_\_\_\_  
**Is anyone covered by Medicare?**  Yes  No If yes: \_\_\_\_\_  
Dependent name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date of birth: (mm/dd/yyyy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Medicare/HIC #: \_\_\_\_\_

Do you have Medicare Part A?  Yes  No Part A begin date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Part A end date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Do you have Medicare Part B?  Yes  No Part B begin date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Part B end date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Type of coverage:  Medical  Dental  Vision  Rx

**Is anyone covered on this application disabled?**  Yes  No **If yes:**

Please complete a disabled dependent application, which you can get from your group administrator, from our website, [www.bcnepa.com](http://www.bcnepa.com) or by calling our service representatives at 1-800-829-8599 or (TTY) 1-866-280-0486.

**Do any dependents have a custodial parent who is responsible for their care?**  Yes\*  No **If yes:**

|  |                               |             |   |
|--|-------------------------------|-------------|---|
| Dependent name:  | Social Security Number: _____ |             | Date of birth: (mm/dd/yyyy)<br>____/____/____ |
| Last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. | Middle name:                  | First name: | Daytime phone: _____                          |
| Residential address:   | City:                         | State:      | ZIP: _____                                    |
|  |                               | County:     |   |

**Is there someone who is financially responsible for the dependent?**  Yes\*  No **If yes:**

|   |                               |             |   |
|---|-------------------------------|-------------|---|
| Dependent name:   | Social Security Number: _____ |             | Date of birth: (mm/dd/yyyy)<br>____/____/____ |
| Organization/last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. | Middle name:                  | First name: | Daytime phone: _____                          |
| Residential address:  | City:                         | State:      | ZIP: _____                                    |
|   |                               | County:     |   |

**Are any dependents continuing coverage as full-time students?**  Yes  No **If yes:**

|  |                               |   |
|--|-------------------------------|---|
| <b>When your dependent child is no longer a full-time student, you must notify the employer through which you are enrolled. Failure to do so may result in the dependent not being able to continue his or her protection on a direct-payment basis without a lapse in coverage.</b> |                               |   |
| Dependent name:  | Social Security Number: _____ | Date of birth: (mm/dd/yyyy)<br>____/____/____ |

|  |   |  |                             |
|--|---|--|-----------------------------|
| Dependent marital status:  | Dependent student status:                   |  | Date of birth: (mm/dd/yyyy) |
| <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married/date of marriage: ____/____/____ | <input type="checkbox"/> Full-time student  | <input type="checkbox"/> Part-time student |                             |
| Dependent employment status:   | Expected date of graduation: ____/____/____ | Name of school: _____                      |                             |
| <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not working   |   |  |                             |

**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 Co. medical or any other information acquired by it under the X VIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. 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 an subjects such person to criminal and civil penalties. If enrolled in a First Priority Health product, I understand that treatment rendered by a provider in the First Priority Health provider 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 non-participating provider, I will be solely responsible for all costs incurred.

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

Group Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

\*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.