

# ENROLLMENT APPLICATION/CHANGE FORM FOR GROUP COVERAGE

**Group Administrator** Must complete all information before enrollment will be processed. Form will be returned if not complete.

Department/agency number:	Medical group number:	
Dental group number:	Vision group number:	
Company name:	Date hired: (mm/dd/yyyy)	Effective date: (mm/dd/yyyy)

**Medical coverage**



BlueCare® Senior



BlueCare HMO  
 BlueCare HMO Plus

Signature required on the Statement of Understanding of Financial Responsibility on back.



BlueCare Traditional  
 BlueCare Comprehensive  
 BlueCare PPO  
 BlueCare QHD PPO  
 BlueCare EPO

**United Concordia Dental**

Dental products are offered by United Concordia Life and Health Insurance.\* This is not a Blue Cross product.

**Davis Vision**

Vision products are offered by HM Life Insurance Company,† administered by Davis Vision, Inc. This is not a Blue Cross product.

Employment status	Employment type	COBRA qualifying event
<input type="checkbox"/> Full-time active employee <input type="checkbox"/> Leave of absence <input type="checkbox"/> Retired <input type="checkbox"/> Terminated <input type="checkbox"/> Active military <input type="checkbox"/> Overseas <input type="checkbox"/> USA <input type="checkbox"/> Other _____	<input type="checkbox"/> New <input type="checkbox"/> Rehire Date rehired: _____ <input type="checkbox"/> Retiree <input type="checkbox"/> Open enrollment <input type="checkbox"/> COBRA Begin date: _____ End date: _____	<input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Termination of coverage <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Death of covered employee <input type="checkbox"/> Dependent child reached limiting age <input type="checkbox"/> Employer's commencement of bankruptcy proceedings
Reason	If you are making a change, please check the appropriate box and complete "Section 1. Applicant Information." If the change refers to a dependent, please complete "Section 2. Dependent Information," and the "Supplemental Information for Dependent Enrollment" form, if applicable.	
<input type="checkbox"/> Changes to coverage <input type="checkbox"/> New enrollment <input type="checkbox"/> Group transfer <input type="checkbox"/> Reinstatement <input type="checkbox"/> Terminate coverage Reason: _____ <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Add dependent <input type="checkbox"/> Add spouse <input type="checkbox"/> Delete dependent/spouse <input type="checkbox"/> New address	Date of event: _____ Date of marriage: _____ Date of event: _____ <input type="checkbox"/> Other _____

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

<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Daytime phone: _____	If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.	Primary Care Physician: _____	Current Patient <input type="checkbox"/>
Social Security Number: _____		Date of birth: (mm/dd/yyyy) _____	PCP or NPI number: _____	Office location: _____	

Are you the employee:  Yes  No If "No," tell us your relationship to the employee: \_\_\_\_\_

Last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	First name: _____	Middle name: _____	E-mail: _____		
Street address: _____	City: _____	State: _____	ZIP: _____	County: _____	Country: _____

**Different mailing address**  Yes  No If yes, all communications will be mailed to this address:

Mailing address: _____	City: _____	State: _____	ZIP: _____	County: _____	Country: _____
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**Section 2. Dependent Information** Please list all family members to be covered. For changes, check "Add" or "Delete."

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. PCP or NPI #	Primary Care Physician	Location	Current Patient
<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"/>	Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Child						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>

\* Dental products are offered by United Concordia Life and Health Insurance, an independent company, and not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates. Continued on back  
 † Vision products are offered by HM Life Insurance Company, administered by Davis Vision Inc. Davis Vision Inc. is an independent company, and not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates.

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

If you answer "Yes" to any of these questions, you must complete and return the "Supplemental Information for Dependent Enrollment" form with this application.

- Is the address for any dependents different from your residence address?  Yes  No
- Do any dependents have a custodial parent who is responsible for their care?  Yes  No
- Do any dependents have other group health insurance/Medicare?  Yes  No
- Is there someone else who is financially responsible for a dependent?  Yes  No
- Are any listed dependents over the dependent age and continuing as full-time students?  Yes  No
- Are any dependents covered on this application disabled?  Yes  No

**Section 3. General Applicant Information**

Do you have other health insurance that will be in effect at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, insurance company: _____		If yes, reason for Medicare coverage (check all that apply): <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual	
Policy ID#: _____		Medicare/HIC #: _____	
Effective date: _____ Termination date: _____		Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your primary language English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disability begin date: _____ End date: _____	
If no, your language: _____		Do you have Medicare part A? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates from: _____ to: _____	
If yes, date of first dialysis: _____		Do you have Medicare part B? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a custodial parent who is responsible for your care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates from: _____ to: _____	
If yes, responsible parent's last name: _____		First name: _____ Middle initial: _____	
Is there someone who is financially responsible for you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Daytime phone: _____	
If yes, date of first dialysis: _____		Street address: _____ City: _____	
A copy of court-initiated documents must be attached to this form.		State: _____ ZIP: _____ Country: _____	

**Section 4. Statement of Understanding of Financial Responsibility for BlueCare HMO Plus**

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 there is no provider in the First Priority Health network that can perform the service, and the service is medically necessary and appropriate, I can request prior authorization to 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 received care from a provider within the First Priority Health 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 First Priority Health. 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: \_\_\_\_\_

**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<sup>SM</sup> 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 Title XVIII 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 and 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 received 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: \_\_\_\_\_