

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 and Reason for Application
- 2) Employee First Name, Middle Initial, Last Name.
- 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. If retired, please indicate retirement date.
- 10) Employee Home Phone Number (including area code)
– Please provide so that we may contact you if we have questions about your application and to better serve you.
- 11) Employee Work Phone Number (including area code)
- 12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).
- 14) To be completed by Account/Administrator only

Items **15** through **18** ask for important information about yourself and each eligible member of your family (**15** yourself, **16** your spouse/ domestic partner, **17-18** your dependents). Please complete all requested information. If relationship is “other”, please indicate the dependent’s relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **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 Maximum Regular Dependent Age, Disabled and/or Act 4 dependent**
If your dependent is over the Maximum Regular Dependent Age and is a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent’s name.

Physician of Record (POR) Information — A Physician of Record is the physician selected by the member, who provides routine care and coordinates other specialized care. Please note that choosing a POR does not impact your benefits or claims payment in any way. Choosing a POR simply helps us to better serve you by connecting you to the practice where most of your health care is received.

- a) **Full Name of Physician of Record (POR) Group Practice** — Indicate the name of the POR Group Practice selected from the Online Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different POR.
- b) **Physician of Record (POR) Number from Provider Directory** — Please indicate the corresponding number for the physician practice you or your dependent chose as a POR from the Online Provider Directory, Practice Information tab.
- c) **Are you an existing Patient of this POR?** — Please check “Yes” or “No” to indicate if you are currently a patient of the POR you chose for yourself or your dependents.

For online provider lookup, go to www.highmarkblueshield.com and search under the “Find a Doctor or Rx” tab. If you need assistance with choosing a POR, please call Member Service at 1-800-345-3806.

Disclaimer: Please note that a provider number may not be available for providers that are located outside of the local servicing area. In this case, a POR cannot be chosen.

- 19) 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. Refer to your Medicare card to complete the Medicare Information section.
- 20) Should be completed by your Account Administrator.
- 21) You must sign and date the form where indicated.

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

HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION



P.O. Box 890172
Camp Hill, PA 17089

EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name			Reason for Application ☐ New Hire ☐ Rehire ☐ Enrollment ☐ Act 4 ☐ Other:		
2) Employee First Name / Middle Initial / Last Name					
3) Street Address		4) City		5) State	6) Zip
7) Social Security Number		8) Effective Date of Coverage Month Day Year		9) Employee Status ☐ Active ☐ Retired (Date) ☐ Hourly ☐ Salary	
10) Employee Phone #—Home ()		11) Employee Phone #—Work ()		12) Employee Hire Date Month Day Year	
13) Check Type of Coverage					
MEDICAL DENTAL VISION DRUG PRODUCT NAME					
Employee Only ☐ ☐ ☐ ☐ ☐					
Insured & Spouse/Domestic Partner ☐ ☐ ☐ ☐ ☐					
Family ☐ ☐ ☐ ☐ ☐					
Parent & Child ☐ ☐ ☐ ☐ ☐					
Parent & Children ☐ ☐ ☐ ☐ ☐					
14) To be completed by Account Administrator only					
Group Number		Report Code Qualifier		Report Code Value	

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)					Do you have other insurance?		Birth Date			Sex F/M	Check If			
							Mo	Dy	Yr		Student Benefits Apply	Dis-abled	Act 4	
15) Self	First Name / Middle Initial / Last Name				Social Security Number		☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice					b) POR Number from Provider Directory			c) Are you an Established Patient? ☐ Yes ☐ No						
16) ☐ Spouse ☐ Dom. Part.* [] []	First Name / Middle Initial / Last Name				Social Security Number		☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice					b) POR Number from Provider Directory			c) Is Spouse/DP an Established Patient? ☐ Yes ☐ No						
17) ☐ Child ☐ Other* [] []	First Name / Middle Initial / Last Name				Social Security Number		☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice					b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐ Yes ☐ No						
18) ☐ Child ☐ Other* [] []	First Name / Middle Initial / Last Name				Social Security Number		☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice					b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐ Yes ☐ No						

*If “domestic partner” or “other” applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner

19) If you checked YES to other insurance, fill in appropriate line: Name of Insurance Carrier: _____ Group No: _____ Effective Date: _____ Name of Policy Holder: _____ Policy Number: _____ Relationship to Highmark Policy Holder: _____ Policy Holder Date of Birth: _____ Policy Holder Employment Status: ☐ Active ☐ Retired (Date) _____	MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:					
	Name of Member		Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
	Last	First		/ /	/ /	/ /
	_____		_____	/ /	/ /	/ /
	_____		_____	/ /	/ /	/ /
	_____		_____	/ /	/ /	/ /
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						

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. 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. 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 Health Services 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 Health Services’ Notice of Privacy Practices is available on Highmark Health Services’ Web site, or from the Highmark Health Services Privacy Office.

20) _____ Authorized Employer Signature	_____ Date	21) _____ Employee Signature	_____ Date
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