



ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

ENROLLING
(Complete sections I, II, IV, and V)

WAIVING
(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date		Employer/Group Name			Group Number		Payroll Location	
First Name		MI	Last Name		Social Security Number (If no SS#, write N/A)			
Address								
City		State	Zip	County	Home/Cell Phone			
Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced				Enrollment Status <input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA Continuant Start Date ____ / ____ / ____ <input type="checkbox"/> Rehired Employee <input type="checkbox"/> HIPAA Life Event <i>(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)</i>				
Full-Time Hire (or Rehire) Date (Month/Day/Year) ____ / ____ / ____			Hours Worked Per Week		Job Title			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (Month/Day/Year) ____ / ____ / ____		Age	Product Selection(s) <input type="checkbox"/> Medical Product Name: _____ <input type="checkbox"/> Vision <input type="checkbox"/> Dental			
Full Name of Physician of Record (POR) Group Practice				POR Number from Provider Directory		Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name		MI	Last Name		Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]			
Social Security Number (If no SS#, write N/A)				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (Month/Day/Year) ____ / ____ / ____		Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental								
Full Name of Physician of Record (POR) Group Practice				POR Number from Provider Directory		Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

[†]If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name		MI	Last Name		Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*			
Social Security Number (If no SS#, write N/A)				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (Month/Day/Year) ____ / ____ / ____		Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental					Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**			
Full Name of Physician of Record (POR) Group Practice				POR Number from Provider Directory		Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory		Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory		Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- For myself
- For family members **ONLY**:
- For myself and **ALL** family members
- For the following family members:

REASON FOR DECLINING MEDICAL COVERAGE:

- Insured under spouse. Please provide spouse's employer and insurance carrier names:

- Other:

VISION

I HEREBY DECLINE VISION COVERAGE:

- For myself
- For family members **ONLY**
- For myself and **ALL** family members
- For the following family members:

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- For myself
- For family members **ONLY**
- For myself and **ALL** family members
- For the following family members:

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. 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 special enrollment (described below) occurs before coverage will be offered.

Employee/Contract Holder Signature

Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's 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, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier		Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement: / /	

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

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark 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.

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 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's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and supporting documentation) to:

Highmark
Attn: Producer Affairs
P.O. Box 890089
Camp Hill, PA 17089-0089

For Ongoing Enrollment: If adding new employees/contract holders or dependents to an existing group, please fax or send Enrollment/Waiver Forms to one of the following addresses:

Fax (800) 290-3301

<https://www.enrollmentandbilling@highmark.com>

Membership Department
P.O. Box 890172
Camp Hill, PA 17089-0172

Insurance or benefit administration may be provided by Highmark Blue Shield, Highmark Health Insurance Company or Highmark Benefits Group (HBG). Information is issued by Highmark Blue Shield on behalf of these companies, which are independent licensees of Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com/QualityAssurance](https://www.discoverhighmark.com/QualityAssurance); or for a paper copy, call 1-855-873-4108.

Highmark Blue Shield does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your member ID card to request these free services (TTY/TDD users may call 711).

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llame al número que aparece en su tarjeta de identificación para solicitar este servicio gratuito. Usuarios de TTY con problemas de audición pueden llamar al 711 para recibir ayuda de forma gratuita.

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，如英語能力有限，請撥打您證件上的號碼，來要求這些免費服務。如您有聆聽障礙需要TTY免費服務，請致電711。

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang akomodasyon para sa limitadong kahusayan sa wikang Ingles pakitawagan ang numero sa iyong ID card para hilingin ang libreng serbisyonang ito. Ang mga gumagamit ng TTY para sa mga may kapansanan sa pagdinig ay maaaring tumawag sa 711 para makatanggap ng libreng tulong.

Nihinaanish niizhónigo bee nihiká' adiiwofigíi binahjí' ts'ídá yéego bidiilkaal, nihí naaltsos nidahoníngíi dóo Bee Atah ídlinígíi nihí hada'dít'éhígíi nihá. T'áá hait'éego da nint'ago níká' iidoowoł, díi Bilagáana Bizaad doo hózq bki'iitiigó, ei Bik'iindáago bee nééhózinígíi éesh bee hane'é bikáá', t'áá jík'eh áká'aná'áwo', éi bich'j' hodílni. Doo hazhó'ó azhdiits'a'gó éi TTY chodayool'ínigíi 711 bich'j' hodílnih, t'áá jík'eh níká'iidoowoł.