HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign. Do not complete shaded areas at bottom of form.

HIGHMARK. Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

Fifth Avenue Place
120 Fifth Avenue Suite 2303
Pittsburgh, PA 15222-3099

EMPLOYEE INFORMATION

1) Employer Name

2) Employee First Name / Last Name

3) Street Address | 4) City | 5) State | 6) Zip

7) Social Security Number | 8) Effective Date of Coverage Mo / Day / Year | 9) Employee Status ❑ Active ❑ Retired ❑ Hourly ❑ Salary

10) Employee Phone #—Day ( ) | 11) Employee Phone #—Evening ( ) | 12) Hire Date Mo / Day / Year

13) Check Type of Coverage	MEDICAL	DENTAL	VISION	DRUG	PRODUCT NAME
Employee Only	❑	❑	❑	❑	❑
Insured & Spouse/Domestic Partner	❑	❑	❑	❑	❑
Family	❑	❑	❑	❑	❑
Parent & Child	❑	❑	❑	❑	❑
Parent & Children	❑	❑	❑	❑	❑

Complete items 14 through 19 where applicable. List eligible participants (If you have additional dependents, attach separate sheet)

	Complete Where Applicable	First Name / Last Name	Social Security Number	Birth Date Mo	Dy	Yr	Sex F/M	Check If Student Over 19	Check If Disabled
14)	Self								
15)	❑ Spouse ❑ Dom. Part.*								
16)	❑ Child ❑ Other*								
17)	❑ Child ❑ Other*								
18)	❑ Child ❑ Other*								

***If "domestic partner" or "other" applies, complete using one of the following codes:** —Grandson, Nephew, Brother (11), —Granddaughter, Niece, Sister (12), —Stepson (13), —Stepdaughter (14), —Male Domestic Partner (17), —Female Domestic Partner (18)

19) Please check one if applicable (If additional space is required, attach a separate sheet). If you ❑, your spouse/domestic partner ❑, or dependent(s) ❑, are enrolled in another Program or Medicare, please give the following information:

Name of Employer (If applicable): _____ Group No: _____
Name of Insurance Carrier: _____ Effective Date: _____
Name of Insured: _____ Is Coverage Still in Effect? ❑ Yes ❑ No
Identification Number: _____
Insurance Carrier Phone #: _____

Please check one if applicable (If additional space is required, attach a separate sheet). If you ❑, your spouse/domestic partner ❑, or dependent(s) ❑, are enrolled in another Program or Medicare, please give the following information:

Name of Employer (If applicable): _____ Group No: _____
Name of Insurance Carrier: _____ Effective Date: _____
Name of Insured: _____ Is Coverage Still in Effect? ❑ Yes ❑ No
Identification Number: _____
Insurance Carrier Phone #: _____

I certify that the information provided on this form is true to the best of my knowledge. 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.

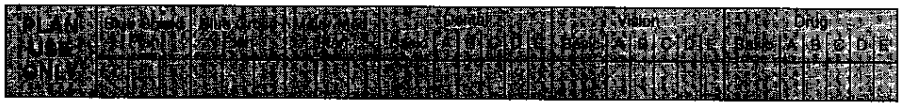
I also authorize any provider or health care services to provide to Blue Cross and Blue Shield, upon request, any information concerning the health, condition or treatment of any covered person whenever such information is considered necessary with respect to (a) administering benefits; (b) conducting bona fide medical research; and (c) when required or authorized by law.

20) _____
Authorized Employer Signature — Date

21) _____
Employee Signature — Date

To be completed by Account/Administrator only

22) Group Number | Payroll Number | Clock Number



HBCBS COPY

JD-7 (R5-01) 1139