DEPENDENT CHILD

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IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	E ective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			Active Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Bene“ts)

Name of Subscriber or Dependent	Health Insurance Claim Number	E ective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								Yes No
								Yes No
								Yes 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 c

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 identi“able health information about me or my enrolled dependents (•Protected Health InformationŽ) 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 Website, or from the Highmark Privacy O ce.

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 all supportin documentation) to the appropriate Highmark Small Group Sales Contact.

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

Fax (800) 290-3301

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/Quality Assurance, or for a paper copy, call 1-855-873-4106.

We do 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 benefits 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 th back of your Member ID card to request these free services (TTY/TDD users may call 711).

Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) and First Priority Health (FPH) are independent licensees of the Blue Cross and Blue Shield Association.
Insurance may be provided by Highmark Blue Cross Blue Shield, FPLIC or FPH. Health care plans are subject to terms of the agreement.