

ENROLLMENT/WAIVER FORM

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

ENROLLING

WAIVING

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date		Employer Name				Group Number		Payroll Location		
Last Name		First Name		MI	Social Security No.			Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Address				Email Address						
City		State	Zip		Home Phone		Work Phone			
Employment Status		Date of Full-Time Hire		Hours Worked	<input type="checkbox"/> COBRA Start Date _____ End Date _____		COBRA REASON: <input type="checkbox"/> Deceased <input type="checkbox"/> Involuntary Lay-Off Date of Event _____ <input type="checkbox"/> Left Employment <input type="checkbox"/> Other _____			
<input type="checkbox"/> Active	<input type="checkbox"/> COBRA	<input type="checkbox"/> Disabled	Mo	Day	Yr	Per Week				

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

Covered Dependents and Relationship	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Sex	Height	Weight	Dependent Status If Over Age 26	Med	Vis	Den
Self			/ /	<input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.* [][]			/ /	<input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> Child <input type="checkbox"/> Other* [][]			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled			
<input type="checkbox"/> Child <input type="checkbox"/> Other* [][]			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled			
<input type="checkbox"/> Child <input type="checkbox"/> Other* [][]			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled			

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship: Other: _____

III WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s)) EMPLOYEE AND EMPLOYER MUST SIGN BELOW

MEDICAL	VISION	DENTAL
I HEREBY DECLINE MEDICAL COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following person(s): _____	I HEREBY DECLINE VISION COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following person(s): _____	I HEREBY DECLINE DENTAL COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following person(s): _____
REASON FOR DECLINING MEDICAL COVERAGE: <input type="checkbox"/> Insured under spouse's contract with the following insurance carrier: _____ <input type="checkbox"/> Other: _____		

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. 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 qualifying event occurs before coverage will be offered.

Employee Signature	Date	Employer Signature	Date
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ONLY SIGN IF YOU ARE WAIVING COVERAGE

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

BOTH EMPLOYEE AND EMPLOYER SIGNATURES ARE REQUIRED FOR WAIVERS

IV ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder
Policy Holder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired - List 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: EMPLOYEE AND EMPLOYER MUST SIGN BELOW

I understand that this form enrolls those eligible persons listed above in the Products 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.

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.

Authorized Employer Signature

Date

Print Company Name

Employee Signature

Date

Print Employee's Name



For New Business:
Highmark
Attn: Producer Affairs (SP 6E)
P.O. Box 890089
Camp Hill, PA 17089-0089

VI MEDICAL HISTORY INFORMATION

Please answer each question below as completely as possible. NOTE: Medical information disclosed in this section will not be used to determine the eligibility of you and/or your dependents to enroll in the coverage requested. **If you or any of your dependents have any of the conditions listed below, please check all numbers and circle the specific condition(s) that apply.**

Then, in the **Explanation** section below, please give details for all diagnosis circled in questions 1 -27. Attach additional sheets if necessary.

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> 1. Cancer, Leukemia, Tumor or Cyst <input type="checkbox"/> 2. Heart Surgery (Angioplasty, Stent or Bypass), Heart Disease, Implanted Pace Maker or Defibrillator, Irregular Heartbeat, Heart Murmur, Heart Regurgitation, Chest Pain, Congestive Heart Failure or Mitral Valve Prolapse <input type="checkbox"/> 3. Vasculitis or Peripheral Vascular Disease <input type="checkbox"/> 4. High Blood Pressure, and/or High Cholesterol <input type="checkbox"/> 5. Emphysema, COPD, Cystic Fibrosis, Asthma or Allergies <input type="checkbox"/> 6. Sleep Apnea, or Disease of the Throat, Ears, Nose, Sinuses or Eyes (except glasses) <input type="checkbox"/> 7. Ulcerative Colitis, Crohn's, Diverticulitis, Stomach Ulcers, Acid Reflux, GERD, Hernia, Gallbladder or Rectal Disorders <input type="checkbox"/> 8. Diabetes Type I or II <input type="checkbox"/> 9. Hypothyroid, Hyperthyroid, Goiter, Pituitary, Pancreas or Glandular Disorders or Disorders requiring Growth Hormones <input type="checkbox"/> 10. Hepatitis (please circle type): A, B, C, or Autoimmune Hepatitis <input type="checkbox"/> 11. Bladder, Kidney, Prostate, Testicular, Uterine, Kidney Failure or Dialysis, Abnormal PAP in the last 5 years or Breast Condition <input type="checkbox"/> 12. Any female to be covered currently Pregnant? Due Date _____. If yes, how many fetuses (single, twins, triplets, etc.). If pregnant, please give details including any complications | <ul style="list-style-type: none"> <input type="checkbox"/> 13. Arthritis (Osteo, Rheumatoid or Other), Joint Replacement, Joint Pain, Lupus, Fibromyalgia, Fractures or Limb Loss <input type="checkbox"/> 14. Neck or Back Pain, Disorders of the Spine or Disc Herniation/Bulging <input type="checkbox"/> 15. Head or Spinal Injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis <input type="checkbox"/> 16. Any blood disorder such as Anemia or Hemophilia <input type="checkbox"/> 17. Aneurysm (Aortic or Cerebral), Blood Clot, TIA or Stroke <input type="checkbox"/> 18. AIDS, HIV, Chronic Fatigue Syndrome, any Immune Suppressed Illness <input type="checkbox"/> 19. Depression, Anxiety, ADD, ADHD, Psychotic Disorder <input type="checkbox"/> 20. Any Drug or Alcohol Problems <input type="checkbox"/> 21. Any Stem Cell or Organ Transplant (planned, recommended or already performed) <input type="checkbox"/> 22. Cigarette or Tobacco use? <input type="checkbox"/> 23. Any hospitalizations in the last 5 years (Please give full details below) <input type="checkbox"/> 24. Any future surgeries discussed, planned or recommended (Please give full details below) <input type="checkbox"/> 25. Currently taking any prescription medications? Please give details below to include the name of the medication and condition for which the medication is needed. <input type="checkbox"/> 26. Are there any other medical conditions not listed above? (Please give full details below) <input type="checkbox"/> 27. In the last five years have you been treated (including medication) for, diagnosed with, or sought treatment from a member of the medical profession for : Macular Degeneration, Retinitis Pigmentosa, Retinopathy? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

VII EXPLANATION SECTION

Provide an explanation for each box marked in questions 1 - 27. Any prescription medications that are **not** in response to the questions above - please list prescription medication and the reason for the medication. If additional space is needed, please attach additional sheets. When completing the application, please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Medications	Date of most recent inpatient stay		Is ongoing treatment required?	If yes, please explain
						From	To		

VIII IMPORTANT: EMPLOYEE/APPLICANT SIGNATURE (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products 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 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. I further acknowledge and

agree that Highmark may disclose enrollment, disenrollment summary health and/or premium billing information requested by the POR (Producer of Record) for purposes of inputting, updating and/or reviewing the same for the above identified business.

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.

Employee
Signature:

Print
Employee Name:

Date: