

ENROLLMENT APPLICATION/CHANGE FORM FOR GROUP COVERAGE


Group Administrator Must complete all information before enrollment will be processed. Form will be returned if not complete.


COMPANY NAME

MEDICAL GROUP NUMBER _____ AGENCY NUMBER _____ DENTAL GROUP NUMBER _____ VISION GROUP NUMBER _____


COMPANY NUMBER _____ DATE HIRED (MM/DD/YY) _____ EFFECTIVE DATE (MM/DD/YY) _____

MEDICAL COVERAGE

 **FIRST PRIORITY LIFE**
 BlueCare PPO
 BlueCare QHD PPO
 BlueCare Traditional
 BlueCare Comprehensive
 BlueCare EPO

 **FIRST PRIORITY HEALTH**
 BlueCare HMO
 BlueCare HMO Plus*

*Signature required on the Statement of Understanding of Financial Responsibility on back.

 **BlueCross of Northeastern Pennsylvania Highmark BlueShield**
 BlueCare Senior

For Administration Use Only

DAVIS VISION Vision products are offered by HM Life Insurance Company,† administered by Davis Vision, Inc. This is not a Blue Cross product.

UNITED CONCORDIA DENTAL Dental products are offered by United Concordia Life and Health Insurance.‡ This is not a Blue Cross product.

Enrolling in an HSA

EMPLOYMENT TYPE

New Rehire
 Date rehired (MM/DD/YY) _____

Retiree
 Open enrollment/qualifying life event

COBRA QUALIFYING EVENT/TERMINATION REASON

Divorce/legal separation
 Voluntary termination of coverage
 Involuntary termination of coverage
 Gross misconduct? Yes No
 Reduction of hours

Death of covered employee
 Dependent child reached limiting age
 Layoff
 Disability leave expired
 Non-disability leave of absence expired

COBRA event date
 BEGIN DATE (MM/DD/YY) _____
 END DATE (MM/DD/YY) _____

REASON If you are making a change, please check the appropriate box and complete "Section 1. Applicant Information." If the change refers to a dependent, please complete "Section 2. Dependent Information" and the Supplemental Information for Dependent Enrollment form, if applicable.

Changes to coverage
 New enrollment
 Group transfer

Reinstatement
 Add dependent
 Add spouse

Delete dependent/spouse
 New address
 Other (Specify): _____

DATE OF EVENT (MM/DD/YY) _____

Section 1. Applicant Information Must complete all information before enrollment will be processed. Form will be returned if not complete.

GENDER M F

MARITAL STATUS
 Single
 Married
 Divorced
 Separated
 Widowed

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH (MM/DD/YY) _____

DAYTIME PHONE _____

ARE YOU THE EMPLOYEE?
 Yes No

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP. Current Patient

PCP or NPI (office #) _____ PRIMARY CARE PHYSICIAN _____ LOCATION/CITY _____

LAST NAME MR. MRS. MISS MS. _____

FIRST NAME _____ **MI** _____

STREET NUMBER _____ **STREET NAME** _____ **CITY** _____

STATE _____ **ZIP** _____ **COUNTRY** _____ **PRIMARY LANGUAGE** _____

EMAIL ADDRESS _____

DIFFERENT MAILING ADDRESS? Yes No If "Yes," all communications will be mailed to this address.

STREET NUMBER _____ **STREET NAME** _____ **CITY** _____

STATE _____ **ZIP** _____ **COUNTRY** _____

(continued on back)

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