Ξ 9 8 Z 5 S 9 HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION Employee must complete items 1 through 13 and sign. Complete Items 15 through 19 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.) mm Z r r o r m m those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls 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 To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly Dom. Part.* any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not Other Authorized Employer Signature Child other Child Other* If you checked YES to other insurance, fill in appropriate line: 3 2 0 πZ --> ZO Complete Where Applicable Policy Holder Employment Status: Policy Holder Date of Birth: Relationship to Highmark Policy Holder: Policy Number: Name of Policy Holder: Name of Insurance Carrier: Self Street Address 2) Employee First Name / Middle Initial / Last Name Social Security Number 1) Employer Name Employee Phone #—Home *If "domestic partner" or "other" applies, complete using one of the following codes: |05| Grandchild, |07| Nephew or Niece, |17| Stepson or Stepdaughter, (29) Domestic Partner Active □ Retired Effective Date: B) Effective Date of Coverage Month Day 11) Employee Phone #—Work First Name / Middle Initial / Last Name (Date) Do you have a Medicare Supplement or other coverage that complements Medicare? Why are you eligible for Medicare? LastFirst MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits: Year Date Name of Member 4) City 9) Employee Status Active 12) Employee Hire Date Reason for Application New Hire Rehire Act 4 Other. Claim Number ☐ Age Day 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 be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Highmark's Web site, or from the Highmark Privacy Office. operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on 5) State 22) Employee Signature ☐ Enrollment ☐ COBRA 6) Zip Disability ☐ Hourly ☐ Salary Year Hourly End Stage Renal Disease Social Security Number Family Parent & Child Insured & Spouse/Domestic Partner **Employee Only** To be completed by Account Administrator only Parent & Children 13) Check Type of Coverage Group Number Date (Mo-Day-Yr) Health Insurance FIIGHMARK. ☐ Yes □ No Part A Effective Date (Mo-Day-Yr) MEDICAL Report Code Qualifier 00000 If YES, then complete #20 If YES, then complete #20 ☐ Yes ☐ No Yes No ☐ Yes ☐ No O Yes O No Yes No complete #20 complete #20 If YES, then If YES, then insurance? have other If YES, then Do you DENTAL 00000 Mo Part B Effective Date (Mo-Day-Yr) NOISIA Birth Date 00000 Dy ***** Membership Department P.O. Box 535193 Date DRUG Pittsburgh, PA 15253-5193 00000 Report Code Vaiue F/M Health Plan Copy Student Benefits Apply PRODUCT NAME Part D Effective Check If 00000 abled 4 2