Broker/Agent Enrollment Application Addendum

This form must accompany all FreedomBlue PPO, FreedomBlue PFFS, and BlueRx enrollment applications submitted by brokers/agents. The completed form must be signed and dated by both the broker/agent and the beneficiary. Commissions will not be paid on policies until the completed Broker/Agent Enrollment Application Addendum is received and processed.

(1) Applicant Information

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Applicant Name | Applicant Medicare Number

(2) Broker/Agent Information

Broker/Agent Name | Broker/Agent Number

Agency Name | Agency Number

(3) Statements of Understanding

The broker/agent explained, and you understand:

- Your costs, including any premiums, any deductibles, copayments and/or coinsurance
- Services covered by the plan
- How to make sure services are covered in full by the plan, such as whether you need to use certain providers
- The written plan materials

The person that is discussing plan options with you is either employed by or contracted with Highmark companies. The person may be compensated based upon your enrollment in a plan.

(4) Signatures

By signing below, you are stating that you agree with the Statements of Understanding in Section 3 above. You also agree that you had an opportunity to ask questions about your options.

Broker/Agent Signature | Date

Member's Signature* | Date

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

If you are the authorized representative, you must provide the following information:

Name: ______________________ Address: ______________________

Phone: ______________________ Relationship to Enrollee: ______________________

Other Insurance Addendum

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please complete and return this form with your application. If you answered NO, you do not need to complete or return this form.

______________________________ - - ______________________________

Name **Medicare Number**

Please specify the type of insurance:
- ☐ Active Employer Group Insurance
- ☐ Veteran's Administration Coverage
- ☐ Federal Black Lung Coverage
- ☐ Workman's Compensation Coverage
- ☐ Retiree Coverage
- ☐ Direct Pay Policy
- ☐ Supplemental Coverage

Please specify type of coverage:
- ☐ Medical Only
- ☐ Medical with Prescription Drugs
- ☐ Dental or Vision Only
- ☐ Prescription Drug Only

Is this insurance provided by: ☐ Your Employer ☐ Your Spouse's Employer ☐ Individual Plan

Does your employer have: ☐1-19 employees ☐20-99 employees ☐more than 100 employees

Does your spouse's employer have: ☐1-19 employees ☐20-99 employees ☐more than 100 employees

Your employer's name: ______________________ **Your insurance name:** ______________________

Your insurance policy #: ______________________ **Your insurance group #:** ______________________

Spouse's employer's name: ______________________ **Spouse's insurance name:** ______________________

Spouse's insurance policy #: ______________________ **Spouse's insurance group #:** ______________________

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Member's Signature* Date

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

If you are the authorized representative, you must provide the following information:

Name: ______________________ Address: ______________________

Phone: ______________________ Relationship to Enrollee: ______________________

Highmark Inc., Highmark Health Insurance Company, and Keystone Health Plan West are health plans with a Medicare contract with the Federal government.