



## HOW TO COMPLETE YOUR ENROLLMENT APPLICATION

Following are instructions for completing the Enrollment Application.  
**Remove instruction sheet to complete application.**  
 All information must be completed as indicated.

### EMPLOYEE INFORMATION

Items 1 through 5 and 10 through 14 ask for information regarding the employee. The information you must complete includes:

- 1) Reason for Application – Please check the appropriate box indicating reason for application.
- 2) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 3) Employee Status: Please check the appropriate box(es) indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.
- 4) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.
- 5) Employee Work Phone Number (including area code)

**Items 6 through 9 should be completed by your Account Administrator.**

- 10) Employer Name.
- 11) Association Name – Please indicate if your Employer is part of an association.
- 12) Employee First Name, Middle Initial and Last Name.
- 13) Employee Street Address, City, State, and Zip Code.
- 14) Check or write in Type of Product and Type of Coverage for which you are enrolling using the appropriate category (Employee, Insured & spouse/domestic partner, parent and child, parent and children, or family).

Items 15 through 25 ask for important information about yourself and each eligible member of your family. Please complete the following information for yourself, your spouse/domestic partner, or your child/dependent. Please indicate the relationship to the employee according to the Relation Codes provided below the ELIGIBLE PARTICIPANTS section.

- 15) Relation Code – Please indicate the appropriate Relation Code for each eligible participant. Please refer to the key (\*) provided on the application below the ELIGIBLE PARTICIPANTS section.

- 16) First Name, Middle Initial and Last Name – Complete the first name, middle initial and last name for each eligible person listed.

- 17) Social Security Number – Please include the Social Security Number of each person.

- 18) Do you have other insurance? – If you or a family member have other medical insurance, including Medicare, respond "Yes" if not, you must respond "No"

- 19) Birth Date (month, day, century and year).

- 20) Sex (Female or Male)

- 21) Check If: Student Over 19 and/or Disabled – If your dependent is over the age of 19 and a full time student or a disabled dependent of any age. Please check (✓) the appropriate column by that dependent's name.

- 22) Full Name of Primary Care Physician (PCP) / Group Practice from Directory – Indicate the name of the Primary Care Physician (PCP) or Group Practice selected from the Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different PCP.

- 23) Are you an existing Patient of this PCP? – Please check "Yes" or "No" to indicate if you are currently a patient of the PCP you chose.

- 24) Primary Care Physician (PCP) Number from Directory – Please indicate the corresponding number for the physician you or your dependent chose as a PCP from the Provider Directory.

- 25) Directory Network Code – Please indicate the Directory Network Code which is located on the front cover of your Provider Directory.

- 26) Complete if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Refer to your Medicare card to complete the Medicare Information Section.

- 27) Your employer and you must sign and date the form where indicated.

**Once the form is completed, retain the last copy for your records.**



Membership Department  
120 Fifth Avenue, Suite 2311  
Pittsburgh, PA 15222-3099



PLEASE PRINT (COMPLETE ALL BUT THE SHADED AREAS)

ENROLLMENT APPLICATION

SHADED AREAS TO BE COMPLETED BY ACCOUNT ADMINISTRATOR ONLY

1. REASON FOR APPLICATION <input type="checkbox"/> NEW HIRE <input type="checkbox"/> REHIRE <input type="checkbox"/> COBRA <input type="checkbox"/> OTHER:		2. EMPLOYEE HIRE DATE		3. EMPLOYEE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY <input type="checkbox"/> RETIRED (DATE) _____		4. HOME TELEPHONE # ( ) ( )		5. WORK TELEPHONE # ( ) ( )		6. EFFECTIVE DATE		7. GROUP NUMBER		8. REPORT CODE QUALIFIER		9. REPORT CODE VALUE	
10. EMPLOYER NAME				11. ASSOCIATION NAME - IF APPLICABLE				14. CHECK TYPE OF COVERAGE EMPLOYEE IS SELECTING: <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PRODUCT NAME _____ <input type="checkbox"/> VISION <input type="checkbox"/> DRUG									
12. EMPLOYEE'S FIRST NAME			MIDDLE INITIAL			LAST NAME			14. CHECK TYPE OF COVERAGE EMPLOYEE IS SELECTING: <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> INSURED & SPOUSE/PARENT & CHILDREN <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT & CHILDREN <input type="checkbox"/> FAMILY								
13. ADDRESS - STREET				CITY				STATE				ZIP					

Complete items 15 through 25 where applicable. List eligible participants (if you have additional dependents, attach separate sheet)

15. Complete Where Applicable	16. First Name / Middle Initial / Last Name	17. Social Security Number	18. Do you have other insurance?	19. Birth Date	20. Sex	21. Check if Student Over 19	22. Full Name of Primary Care Physician (PCP)	23. Established Patient?	24. PCP Number from Directory	25. Directory Network Code
Self			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #26	Mo Dy Yr	F/M			<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #26					<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #26					<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #26					<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Child <input type="checkbox"/> Other*			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, then complete #26					<input type="checkbox"/> YES <input type="checkbox"/> NO		

\*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

26. If you checked YES to other insurance, fill in appropriate line: Name of Insurance Carrier: _____ Effective Date: _____ Group No: _____		MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits: Last Name First		Part A Effective Date (Mo-Day-Yr)		Part B Effective Date (Mo-Day-Yr)		Part D Effective Date (Mo-Day-Yr)	
Name of Policy Holder: _____ Policy Number: _____ Relationship to Highmark Policy Holder: _____ Policy Holder Date of Birth: _____ Policy Holder Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired (Date) _____		Why are you eligible for Medicare? <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Do you have a Medicare Supplement or other coverage that complements Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Health Insurance Claim Number					

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 understand that this form enrolls those eligible persons listed above in the Medical Plan 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.

27. \_\_\_\_\_ Date \_\_\_\_\_ Authorized Employer Signature \_\_\_\_\_ Date \_\_\_\_\_ Employee Signature \_\_\_\_\_

MARGINAL WORDS