

# INSTRUCTIONS FOR COMPLETING YOUR ENROLLMENT/WAIVER APPLICATION AND CHANGE FORM



An Independent Licensee of the Blue Cross and Blue Shield Association

## The descriptions below should be used when completing applicable sections of your Enrollment/Waiver Application and Change Form.

In the top right hand corner please list the Product Name under which you are enrolling. Then indicate the **Type of Coverage** that you have selected for you and your eligible dependents (e.g. employee only, two person, etc.)

**Employee/Applicant Information (Section I):** This section must always be completed even if your coverage has not changed.

• **Effective Date of Coverage** – The effective date of new coverage or, in the event of a change in existing coverage, the effective date of the change.

• **Group Number** – To be completed only if the reason for the application is COBRA, dependent status changes or addition of an Act 4 eligible dependent (i.e. qualified dependent up to Age 30.)

**Covered Dependent Enrollment/Change Information (Section II):** This section requires important information about yourself and each eligible member of your family. If relationship is "Domestic Partner" or "Other", please indicate the dependent's relationship to the employee using the codes provided on the application.

**Do you have other insurance?** – If you or your family members have other medical insurance, including Medicare, respond "yes." If not, you **must** respond "no."

• **Check If Disabled, Student over 19 or Act 4** (dependents up to age 30) – If your dependent is a full time student (age 19 or over), an eligible disabled dependent (any age) or entitled to enroll for coverage under Act 4 (qualified dependent up to age 30), please check the appropriate column by that dependent's name. Act 4 eligibility is at the discretion of the employer.

• **Dependent Changes** – If adding or terminating a dependent, check the appropriate box. Please be sure to include the date of the event leading to this change.

• **Other Changes** – This column should be used to indicate changes in either your coverage and/or that of your dependents. Please check the appropriate box and include the date of the event leading to this change.

• **Cancel/COBRA Reasons** – When you and/or your dependents enroll in COBRA, the reason must be indicated.

• **Additional Comments** – If additional space is needed to describe any changes, this can be documented in Section VIII.

**Waiver Information (Section III):** This section must be signed and indicate the reason why you are waiving group coverage for yourself and/or your dependents.

**About Your Other Group or Non-Group Health Insurance Coverage and Medicare (Section IV):** If you checked "yes" to the question "Do you have other insurance?" in Section II, then you must complete this section by identifying all other coverages each enrollee has.

**Authorized Signature's (Required) (Section V):** This section must be completed in all cases. Your signature authorizes the enrollment of you and your dependents under the coverage selected. Both your signature and your employer's signatures are required.

**Reminder: In order for your request to be processed, you must complete each of the Sections indicated below:**

**Initial Enrollment:** Complete Sections I, II, IV and V

**Waiving Coverage:** Complete Sections I and III

**Changing Existing Coverage:** Complete Sections I, II, IV and V

**Changing Existing Coverage and Adding Dependent(s):** Complete Sections I, II, IV and V



**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 Policyholder
Policyholder Date of Birth / /	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired - List Date of Retirement: / /	Relationship to Policyholder	Policy Number

**Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)**

	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Self - First Name /	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Spouse - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /
Dependent - First Name	Last Name	Part A Effective Date / /	Part B Effective Date / /	Part D Effective Date / /

Health Insurance Claim Number	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
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**V. IMPORTANT: Authorized Signatures (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.

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 Name \_\_\_\_\_



Highmark  
P.O. Box 890172  
Camp Hill, PA 17089-0172

or

Fax to: 888-567-5685

<b>Office Use Only.</b> Do not write in the spaces below.
Group Number
Report Code Qualifier
Report Code Value