




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.

Department/Agency number: _____		Medical group number: _____		Medical Coverage  BlueCross of Northeastern Pennsylvania Highmark BlueShield <small>Member of the Blue Cross and Blue Shield Association</small> <input type="checkbox"/> BlueCare® Senior  FIRST PRIORITY HEALTH <small>Member of the Blue Cross and Blue Shield Association</small> <input type="checkbox"/> BlueCare HMO <input type="checkbox"/> BlueCare HMO Plus Signature required in the Statement of Understanding of Financial Responsibility on back.  FIRST PRIORITY LIFE <small>Member of the Blue Cross and Blue Shield Association</small> <input type="checkbox"/> BlueCare Traditional <input type="checkbox"/> BlueCare Comprehensive <input type="checkbox"/> BlueCare PPO <input type="checkbox"/> BlueCare QHD PPO <input type="checkbox"/> BlueCare EPO	For Administration Use Only		
Dental group number: _____		Vision group number: _____					
Company name: LUZERNE COUNTY		Date hired: (mm/dd/yyyy) _____	Effective date: (mm/dd/yyyy) _____				
Employment status <input type="checkbox"/> Full-time active employee <input type="checkbox"/> Leave of absence <input type="checkbox"/> Retired <input type="checkbox"/> Terminated <input type="checkbox"/> Active Military <input type="checkbox"/> Overseas <input type="checkbox"/> USA <input type="checkbox"/> Other _____		Employment type <input type="checkbox"/> New <input type="checkbox"/> Rehire Date rehired: _____ <input type="checkbox"/> Retiree <input type="checkbox"/> Open enrollment <input type="checkbox"/> COBRA Begin date: _____ End date: _____		COBRA qualifying event <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Voluntary termination of coverage <input type="checkbox"/> Involuntary termination of coverage Gross misconduct? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Death of covered employee <input type="checkbox"/> Dependent child reached limiting age <input type="checkbox"/> Layoff <input type="checkbox"/> Disability leave expired <input type="checkbox"/> Non-disability leave of absence expired			
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.							
<input type="checkbox"/> Changes to coverage <input type="checkbox"/> New enrollment <input type="checkbox"/> Group transfer <input type="checkbox"/> Reinstatement <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Add dependent <input type="checkbox"/> Add spouse <input type="checkbox"/> Delete dependent/spouse <input type="checkbox"/> New address		Date of event: _____ Date of marriage: _____ Date of event: _____ <input type="checkbox"/> Other _____			

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

<input type="checkbox"/> Male	Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	Daytime phone	If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.	Primary Care Physician: _____		Current Patient <input type="checkbox"/>
<input type="checkbox"/> Female		<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed				PCP or NPI number: _____	Office location: _____	
Social Security Number: _____					Date of birth: (mm/dd/yyyy) _____				

Are you the employee? Yes No If "No," tell us your relationship to the employee:

Last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.			First name: _____	Middle name: _____	Email: _____				
Street address: _____				City: _____	State: PA	ZIP: _____	County: _____	Country: _____	
Different mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," all communications will be mailed to this address:									
Mailing address: _____				City: _____	State: _____	ZIP: _____	County: _____	Country: _____	

Section 2. Dependent Information Please list all family members to be covered. For changes, check "Add" or "Delete."

Add	Delete	Social Security Number	Gender	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)	if you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP.			Current Patient	
								Medical	Dental	Vision		PCP or NPI
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

* Dental products are offered by United Concordia Life and Health Insurance, an independent company, and not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates.
 * Vision products are offered by HM Life Insurance Company, administered by Davis Vision Inc. Davis Vision is an independent company not affiliated with Blue Cross of Northeastern Pennsylvania or its licensed affiliates.

Continued on back

Section 2. Dependent Information (Continued)

If you answer "Yes" to any of these questions, you must complete and return the "Supplemental Information for Dependent Enrollment" form with this application.

- Is the address for any dependents different from your residence address? Yes No
- Do any dependents have a custodial parent who is responsible for their care? Yes No
- Do any dependents have other group health insurance/Medicare? Yes No
- Is there someone else who is financially responsible for a dependent age 19 or older? Yes No
- Are any listed dependents covered on this application disabled? Yes No
- Are any dependents age 19 or over and continuing as full-time students? Yes No

If any listed dependents are over the dependent age and continuing as full-time students, please complete for each student:

Dependent name: _____	Social Security Number: _____	Date of birth: (mm/dd/yyyy) _____/_____/_____		
Dependent marital status: <input type="checkbox"/> Married ___/___/___ <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Dependent employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Dependent student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Expected date of graduation (mm/dd/yyyy): ___/___/___ Name of school: _____
Dependent name: _____	Social Security Number: _____	Date of birth: (mm/dd/yyyy) _____/_____/_____		
Dependent marital status: <input type="checkbox"/> Married ___/___/___ <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Dependent employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Dependent student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Expected date of graduation (mm/dd/yyyy): ___/___/___ Name of school: _____

Section 3. General Application Information

Do you have other health insurance that will be in effect at the same time as this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, insurance company: _____	If yes, reason for Medicare coverage (check all that apply): <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Medicare/HIC _____
Policy ID#: _____	Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
Effective date: _____ Termination date: _____	Disability begin date: _____ End date: _____
Is your primary language English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, your language: _____	Do you have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a custodial parent who is responsible for your care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of first dialysis: _____
Is there someone who is financially responsible for you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicare part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates from _____ to _____
A copy of court-initiated documents must be attached to this form.	Do you have Medicare part B? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates from _____ to _____
If yes, responsible parent's last name: _____	First name: _____ Middle initial: _____ Daytime phone: _____
Street address: _____	City: _____ State: _____ ZIP: _____ Country: _____

Section 4. Statement of Understanding of Financial Responsibility for BlueCare HMO Plus

I understand that treatment rendered by a provider in the First Priority Health (FPH) provider network will be paid at the highest level of benefits. I also understand that if there is no provider in the FPH network that can perform the service, and the service is medically necessary and appropriate, I can request prior authorization to a BlueCard® or non-participating provider and receive care at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the FPH network and I will be responsible for the applicable deductible and coinsurance. I understand that my plan does not provide coverage for benefits received from a non-participating provider without prior approval from FPH. I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

Applicant Signature _____ Date: _____

Section 5. Conditions of Enrollment Please sign this section of the form. The form will not be processed without your signature.

I hereby apply for enrollment as checked hereon, made available to me through the groups with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and group literature indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents, listed above, to enroll them in a Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/ First Priority Health®/First Priority Life Insurance Company® health care plan. I authorize the Social Security Administration to furnish Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/First Priority Health, First Priority Life Insurance Co. medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. If enrolled in a First Priority Health product, I understand that treatment rendered by a provider in the First Priority Health provider network will be paid at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the First Priority Health network and I will be responsible for the applicable deductible and coinsurance, I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

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.

Applicant Signature _____ Date: _____

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.

Group Administrator Signature (applies to all changes) _____ Date: _____