

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.

COMPANY NAME
 L U Z E R N E C O U N T Y

MEDICAL GROUP NUMBER: 6 9 6 7 5 - AGENCY NUMBER: DENTAL GROUP NUMBER: VISION GROUP NUMBER: 3 1 0 1 7 -

COMPANY NUMBER: DATE HIRED (MM/DD/YY): EFFECTIVE DATE (MM/DD/YY):

MEDICAL COVERAGE

FIRST PRIORITY LIFE
 BlueCare PPO
 BlueCare® Traditional
 BlueCare Comprehensive

BlueCare QHD PPO
 BlueCare EPO

FIRST PRIORITY HEALTH
 BlueCare HMO
 BlueCare HMO Plus*
 BlueCare Senior

*Signature required on the Statement of Understanding of Financial Responsibility on back.

BlueCross of Northeastern Pennsylvania Highmark BlueShield
Independent Licensee of the Blue Cross and Blue Shield Association
 ®Registered Mark of the Blue Cross and Blue Shield Association

For Administration Use Only

DAVIS VISION Vision products are offered by HM Life Insurance Company,¹ administered by Davis Vision, Inc. This is not a Blue Cross product.

UNITED CONCORDIA DENTAL Dental products are offered by United Concordia Life and Health Insurance.² This is not a Blue Cross product.

Enrolling in an HSA

EMPLOYMENT TYPE
 New Rehire
 Date rehired (MM/DD/YY): Retiree
 Open enrollment/qualifying life event

COBRA QUALIFYING EVENT/TERMINATION REASON
 Divorce/legal separation
 Voluntary termination of coverage
 Involuntary termination of coverage
 Gross misconduct? Yes No
 Reduction of hours

Death of covered employee
 Dependent child reached limiting age
 Layoff
 Disability leave expired
 Non-disability leave of absence expired

COBRA event date
 BEGIN DATE (MM/DD/YY): END DATE (MM/DD/YY):

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.

Changes to coverage Reinstatement Delete dependent/spouse
 New enrollment Add dependent New address
 Group transfer Add spouse Other (Specify):

DATE OF EVENT (MM/DD/YY):

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

GENDER: M F MARITAL STATUS: Single Married Divorced Separated Widowed

SOCIAL SECURITY NUMBER: DATE OF BIRTH (MM/DD/YY): DAYTIME PHONE:

ARE YOU THE EMPLOYEE? Yes No

If you are enrolling in BlueCare HMO or BlueCare HMO Plus, you must select a PCP. Current Patient

PCP or NPI (office #): PRIMARY CARE PHYSICIAN: LOCATION/CITY:

LAST NAME MR. MRS. MISS MS. FIRST NAME MI

STREET NUMBER STREET NAME CITY

STATE ZIP COUNTY COUNTRY PRIMARY LANGUAGE

EMAIL ADDRESS:

DIFFERENT MAILING ADDRESS? Yes No If "Yes," all communications will be mailed to this address.

STREET NUMBER STREET NAME CITY

STATE ZIP COUNTY COUNTRY

(continued on back)

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