



**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?  Yes  No
- Are any dependents listed over the dependent age and continuing as full-time students?  Yes  No
- Are any dependents covered on this application disabled?  Yes  No

**Section 3. General Applicant 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 |  |
| Policy ID#: _____   |  | Medicare/HIC #: _____  |  |
| Effective date: _____ Termination date: _____   |  | Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Is your primary language English? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Disability begin date: _____ End date: _____   |  |
| If no, your language: _____   |  | Do you have Medicare part A? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Do you have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | Dates from: _____ to: _____  |  |
| If yes, date of first dialysis: _____   |  | Do you have Medicare part B? <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                             |  | Dates from: _____ to: _____  |  |
| If yes, responsible parent's last name: _____   |  | First name: _____ Middle initial: _____  |  |
| Is there someone who is financially responsible for you? <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |  | Daytime phone: _____   |  |
| If yes, date of first dialysis: _____   |  | Street address: _____ City: _____  |  |
| A copy of court-initiated documents must be attached to this form.  |  | State: _____ ZIP: _____ Country: _____   |  |

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

I understand that care provided within 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 will be considerably higher than if I received 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 First Priority Health. 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<sup>SM</sup> 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. 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: \_\_\_\_\_

Group Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_