APPLICATION FOR NEW 2019 INDIVIDUAL/FAMILY PLAN HEALTH INSURANCE

This Application is for coverage during the calendar year 2019.

PLEASE COMPLETE STEPS 1–5.

STEP 1) Tell us about yourself and your household.

STEP 2) Choose your plan. Find your county in the list below and go to the page number provided to choose your plan.

COUNTY	PAGE #	COUNTY	PAGE #	COUNTY	PAGE #
Allegheny	5	Clearfield	6	Lawrence	6
Armstrong	6	Crawford	6	McKean	6
Beaver	6	Elk	6	Mercer	6
Bedford	6	Erie	5	Potter	6
Blair	6	Fayette	6	Somerset	6
Butler	6	Forest	6	Venango	6
Cambria	6	Greene	6	Warren	6
Cameron	6	Huntingdon	6	Washington	5
Centre	6	Indiana	6	Westmoreland	5
Clarion	6	Jefferson	6		

STEP 3) Tell us about other health insurance. **Incomplete information in STEP 3 may delay the processing of your Application.**

STEP 4) Select your communication preferences.

STEP 5) Sign and send your completed Application (ALL PAGES) and first month's premium payment to Highmark. If you are applying for a Special Enrollment Period, please include this completed application along with The Special Enrollment Period Form and all necessary, supporting documentation.

If you are an insurance agent/producer, please complete the Producer Certificate on the Highmark online producer portal.

To submit your Application faster, please use one of these options to enroll:

- **Online:** **www.DiscoverHighmark.com/individuals-families**
- **By phone:** **1-855 822-6927**

If you are shopping for conversion or HIPAA coverage, please refer to the Appendix at the conclusion of this Application.

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, or Highmark Choice Company, all of which are independent licensees of the Blue Cross Blue Shield Association.

THANK YOU FOR YOUR INTEREST IN HIGHMARK.

To ensure that your Application is processed as quickly as possible, please be sure to:

- Print letters and numbers clearly.
- Check to make sure that the Application is filled out completely. If a specific section does not apply to you please mark as "N/A".
- Ensure that you, your spouse/domestic partner if both are applying for coverage, or the parent/guardian of a child applicant sign and date the Application.
- Return your completed Application and payment to Highmark by one of the following methods. **PLEASE RETURN ALL PAGES OF THE APPLICATION.**

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to your situation, please mark as 'N/A'.

WHO CAN ENROLL IN THE PLANS LISTED ON THIS APPLICATION?

You can enroll in one of these plans, regardless of your age, if:

- You want to purchase directly from Highmark and NOT through the Health Insurance Marketplace. **Plans available on this Application do not apply Federal Premium Tax Credits or Cost-Sharing Reductions.** If you are unsure if you qualify for financial help, including Federal Premium Tax Credits or Cost-Sharing Reductions, please contact the Health Insurance Marketplace at www.HealthCare.gov or 1-800-318-2596.
- **You are not entitled to benefits under Medicare Part A, enrolled in Medicare Part B, Medical Assistance, or CHIP**
- You meet eligibility guidelines listed in Step 5 of this Application
- You reside in one of the counties listed on pages 5 – 6 of the Application

DO YOU NEED CONVERSION OR HIPAA COVERAGE?

Are you converting from group to individual coverage because you lost your Highmark group coverage? You may be eligible for an individual Conversion plan that covers you beginning on the date your Highmark group coverage ends. **To learn more and apply, please refer to the Appendix on page 11 of the Application.**

IF YOU CHOOSE AN HMO PLAN.

If you choose an HMO plan, you are required to select a PCP to provide preventive care and immunization for each covered family member. Indicate the provider's name and PCP ID Number for each family member listed in STEP 1 of this Application. To locate a PCP near you:

1. Call our Member Service team at **1-800-544-6679**

   OR

2. Visit **www.HighmarkBCBS.com** and follow these instructions:
   A. Select **FIND A DOCTOR OR RX**
   B. Select Find a **Doctor, Hospital or other Medical Provider**
   C. Verify the location and distance to the nearest provider on the left side of your screen
   D. Enter "primary care" into the search field and select **Pick a Plan** and Select the HMO plan name that you selected in STEP 3 of this application
   E. Click on the **SEARCH** button to locate PCPs near you who participate in your plan
   F. Select **See More** to learn more about a specific PCP
   G. Click **More Details** and make sure that the PCP is accepting new patients if you are not already an established patient of that PCP. Then select **Physician Details** to locate the PCP's nine-digit Physician ID. Do this for each family member listed on the Application. You may select a different PCP for each family member.

NEED HELP?

- **Call with questions or to enroll over the phone:** 1-855-822-6927
- **Enroll online:** www.DiscoverHighmark.com/individuals-families
- **For in-person visit:** Your local Highmark Insurance store (www.HighmarkDirect.com)
- **If you work with an insurance agent/producer:** Please call or visit him/her directly
- **For instructions on how to submit your completed application**, refer to STEP 5 on page 9.

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STEP 1 TELL US ABOUT YOURSELF

Complete this section if:

- You are applying for health insurance through Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company.
- You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).
- If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Check this box ☐ and provide your child's information in STEP 1.

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

HOME ADDRESS			APARTMENT NUMBER
CITY	**STATE**	**ZIP CODE**	**COUNTY**
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			**APARTMENT NUMBER**
CITY	**STATE**	**ZIP CODE**	**COUNTY**

☐ Check here if you don't have a home address. You still need to give a mailing address.

HOME PHONE NUMBER (NON-MOBILE)	MOBILE PHONE NUMBER	PREFERRED CONTACT (SELECT ONLY ONE)
( )	( )	☐ Home ☐ Mobile

EMAIL ADDRESS	
PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	**PREFERRED LANGUAGE READ (IF NOT ENGLISH)**

☐ Check here if person listed in STEP 1 is applying for coverage for himself/herself ONLY.

PRIMARY CARE PHYSICIAN (REQUIRED FOR HMO)	☐ Check here if presently a patient of this physician.	PCP ID NUMBER (REQUIRED FOR HMO) *

*To find your PCP ID Number, please refer to the instructions on page 2 of this Application.

1. **REQUIRED** If you will be covered under the plan and you are 18 years of age and older:
   Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

Question 1 is required and must be completed or your Application will be delayed.

2. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability. Call us at 1-855-822-6927. You can also call TTY at 711 or visit one of our Highmark Insurance stores to receive assistance free of charge.

GO TO STEP 1 Household

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STEP 1 TELL US ABOUT YOUR HOUSEHOLD

Tell us about everyone who is applying for coverage. Attach additional sheets of paper if needed. Eligible dependents include:

- Your spouse
- Your domestic partner
- Your children who are under age 26
- Your spouse's children who are under age 26
- Your domestic partner's children who are under age 26

The plan and deductible option you choose will apply to everyone covered by your plan.

PERSON 2

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED BY HMO)	☐ Check here if presently a patient of this physician.	PCP ID NUMBER (REQUIRED FOR HMO) *

1. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
   If No, list address: ____________________
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

   Question 2 is required and must be completed or your Application will be delayed.
3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-822-6927. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

PERSON 3

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED BY HMO)	☐ Check here if presently a patient of this physician.	PCP ID NUMBER (REQUIRED FOR HMO) *

1. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
   If No, list address: ____________________
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

   Question 2 is required and must be completed or your Application will be delayed.
3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-822-6927. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

PERSON 4

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (REQUIRED BY HMO)	☐ Check here if presently a patient of this physician.	PCP ID NUMBER (REQUIRED FOR HMO) *

1. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
   If No, list address: ____________________
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

   Question 2 is required and must be completed or your Application will be delayed.
3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-822-6927. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

*To find your PCP ID Number, please refer to the instructions on page 2 of this Application.

GO TO STEP 2 Plan Selection

Applicant's Last Name	First Name

STEP 2 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Allegheny, Washington, Westmoreland

REMINDER: If you select an HMO plan, you must select a PCP in STEP 1 for each member applying for coverage on this Application.

I am/we are applying for **new** coverage under:

Highmark Choice Company Group Number: 058000-00

- ☐ **my Direct Blue HMO Silver 0 –** Annual Deductible: $0 Individual/$0 Family
- ☐ **my Direct Blue HMO Gold 1000 – 2 Free PCP Visits –** Annual Deductible: $1,000 Individual/$2,000 Family
- ☐ **my Direct Blue HMO Silver 2400 – 2 Free PCP Visits –** Annual Deductible: $2,400 Individual/$4,800 Family
- ☐ **my Direct Blue HMO Silver 3500 – 2 Free PCP Visits –** Annual Deductible: $3,500 Individual/$7,000 Family
- ☐ **my Direct Blue HMO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family
- ☐ **my Direct Blue HMO Silver 4450 HSA –** Annual Deductible: $4,450 Individual/$8,900 Family
- ☐ **my Direct Blue HMO Bronze 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family

Highmark Health Insurance Company Group Number: 036000-00

- ☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ☐ **Major Events Blue PPO, a Community Blue Plan 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family
  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Erie

I am/we are applying for **new** coverage under:

Highmark Choice Company Group Number: 058000-00

- ☐ **my Direct Blue Erie HMO Silver 0 –** Annual Deductible: $0 Individual/$0 Family
- ☐ **my Direct Blue Erie HMO Gold 1000 – 2 Free PCP Visits –** Annual Deductible: $1,000 Individual/$2,000 Family
- ☐ **my Direct Blue Erie HMO Silver 2400 – 2 Free PCP Visits –** Annual Deductible: $2,400 Individual/$4,800 Family
- ☐ **my Direct Blue Erie HMO Silver 3500 – 2 Free PCP Visits –** Annual Deductible: $3,500 Individual/$7,000 Family
- ☐ **my Direct Blue Erie HMO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family
- ☐ **my Direct Blue Erie HMO Silver 4450 HSA –** Annual Deductible: $4,450 Individual/$8,900 Family
- ☐ **my Direct Blue Erie HMO Bronze 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family

Highmark Health Insurance Company Group Number: 036000-00

- ☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000

Highmark Blue Cross Blue Shield Group Number: 037000-00

- ☐ **Major Events Blue PPO, a Community Blue Plan 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family
  [Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

GO TO STEP 3 Other Health Insurance

Please complete the form below.

Policy Holder Name (First, Middle, Last): ______________________

Social Security Number: ______________________

Monthly Premium for the plan you selected, based on applicants indicated on this Application: ______________________

Payment Enclosed: $__________ Group Number (*see* ***bold, blue*** *eight-digit number; listed above plan selection*): ______________________

Failure provide complete information in the above form may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 2 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Blair, Cambria, Somerset

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

☐ **my Direct Blue Conemaugh EPO Silver 0 –** Annual Deductible: $0 Individual/$0 Family
☐ **my Direct Blue Conemaugh EPO Gold 1000 – 2 Free PCP Visits –** Annual Deductible: $1,000 Individual/$2,000 Family
☐ **my Direct Blue Conemaugh EPO Silver 2400 – 2 Free PCP Visits –** Annual Deductible: $2,400 Individual/$4,800 Family
☐ **my Direct Blue Conemaugh EPO Silver 3500 – 2 Free PCP Visits –** Annual Deductible: $3,500 Individual/$7,000 Family
☐ **my Direct Blue Conemaugh EPO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family
☐ **my Direct Blue Conemaugh EPO Silver 4450 HSA –** Annual Deductible: $4,450 Individual/$8,900 Family
☐ **my Direct Blue Conemaugh EPO Bronze 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family
☐ **Major Events PPO, a Community Blue Plan 7900 –** Annual Deductible $7,900 Individual/$15,800 Family

[Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

Highmark Health Insurance Company Group Number: 036000-00

☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Armstrong, Beaver, Butler, Clarion, Crawford, Forest, Warren

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

☐ **my Direct Blue EPO Silver 0 –** Annual Deductible: $0 Individual/$0 Family
☐ **my Direct Blue EPO Gold 1000 – 2 Free PCP Visits –** Annual Deductible: $1,000 Individual/$2,000 Family
☐ **my Direct Blue EPO Silver 2400 – 2 Free PCP Visits –** Annual Deductible: $2,400 Individual/$4,800 Family
☐ **my Direct Blue EPO Silver 3500 – 2 Free PCP Visits –** Annual Deductible: $3,500 Individual/$7,000 Family
☐ **my Direct Blue EPO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family
☐ **my Direct Blue EPO Silver 4450 HSA –** Annual Deductible: $4,450 Individual/$8,900 Family
☐ **my Direct Blue EPO Bronze 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family
☐ **Major Events Blue PPO, a Community Blue Plan 7900 -** Annual Deductible: $7,900 Individual/$15,800 Family

[Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

Highmark Health Insurance Company Group Number: 036000-00

☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Bedford, Cameron, Centre, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Group Number: 037000-00

☐ **Major Events PPO, a Community Blue Plan 7900 –** Annual Deductible $7,900 Individual/$15,800 Family

[Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

Highmark Health Insurance Company Group Number: 036000-00

☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000 Family

GO TO STEP 3 Other Health Insurance

Please complete the form below.

Policy Holder Name (First, Middle, Last):____________________

Social Security Number:____________________

Monthly Premium for the plan you selected, based on applicants indicated on this Application:____________________

Payment Enclosed: $__________ Group Number (*see **bold, blue** eight-digit number; listed above plan selection*):____________________

Failure to provide complete information in the above form may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

STEP 3 TELL US ABOUT OTHER HEALTH INSURANCE

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ☐ Yes ☐ No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No

   Individuals entitled to benefits under Medicare Part A or enrolled in Medicare Part B are not permitted to enroll in new coverage made available through this application. If you have included any Medicare enrolled/entitled individuals in STEP 1 of this Application they must be removed. To learn more about Medicare options, go to www.ssa.gov or visit the nearest Social Security Administration (SSA) office.

3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Highmark policy. ☐ Yes ☐ No

If you answered "Yes" to any question above, complete question 4. If you answered "No," skip question 4 and go to question 5.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

   Name of Insurance Carrier: ______________________ Group Number: ____________

   Name of Policy Holder: ______________________ Effective Date: ____________

   Policy Number: ____________ Relationship to Applicant: ____________

   Policy Holder's Date of Birth: ____________ Policy Holder's Employment Status: ____________

5. Will you or any of your family members who are applying for this coverage be receiving premium payment assistance or grants from a third party payer*? ☐ Yes ☐ No ☐ I'm Not Sure

   If you answered Yes or I'm Not Sure, please indicate the type of third-party making payments to you or to Highmark on your behalf:

   ☐ A family member

   ☐ An employer

   ☐ A Ryan White HIV/AIDS program

   ☐ A health care provider or supplier

   ☐ An Indian Tribe, tribal organization, or urban Indian organization

   ☐ A local, State or Federal government program, including a grantee thereof

   ☐ An IRS-recognized 501(c)(3) organization (nonprofit)

   ☐ Other (please specify): ______________________

*A third party payer would be any person or organization or entity, that is paying all or some portion of your/your family's premium to Highmark, or directly to you/your family by means such as cash, check, money order, prepaid debit card, credit card or electronic fund transfers.

I/we acknowledge that I/we have an ongoing obligation to report to Highmark any changes relating to premium payment assistance or grants made by a third party payer.

GO TO STEP 4
Communication Preferences

Applicant's Last Name	First Name

STEP 4 SELECT COMMUNICATION PREFERENCES

You have the opportunity to receive materials related to your Highmark coverage electronically. This would include email alerts and notifications, whenever available, for the information such as: Your Agreement and Outline of Coverage, Insurance Plan Notices; Health and Wellness Notices such as wellness, savings and more and Member Newsletters.

You have the opportunity to change this information at any time by accessing the Member website or calling Member Services. You also have the ability to request a printed copy at any time by calling Member Services at the number provided on the Application.

Would you like to receive your Highmark insurance coverage materials electronically? (Please select only one option?)

☐ Yes! I would like to receive my materials electronically so that I can view my information quickly & securely online

☐ No, thank you. Please continue to send me all materials in paper form

Once you receive your membership information, you will have the ability to register for the member website and have the opportunity to change your contact preferences at that time, or by calling the Member Service number on the back of your member identification (ID) card upon receipt.

Go to HighmarkBCBS.com to review the Contact Preferences Term and Conditions for complete details regarding selecting or changing communication preferences.

To ensure that you receive your member materials by your preferred method, you must notify Highmark if your phone number or email address change.

GO TO STEP 5 Submission

Applicant's Last Name	First Name

STEP 5 SIGN AND SEND YOUR COMPLETED APPLICATION

Send in your completed Application and payment to Highmark by one of the following methods. **PLEASE RETURN ALL PAGES OF THE APPLICATION.** If a specific section does not apply to you, please mark as 'N/A'. Make your check or money order payable to Highmark for your first full premium due. See rates for details. Please include the correct group number (listed in Step 2 on pages 5 & 6 and in the Appendix for Conversion or HIPAA coverage) on your check or money order.

U.S. MAIL:

Include your completed, signed Application along with your first premium payment to:
Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

DROP YOUR APPLICATION AND PAYMENT OFF AT A HIGHMARK INSURANCE STORE:

For locations, please visit www.HighmarkDirect.com

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your first premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

NEED HELP?

- **Call with questions or to enroll over the phone:** 1-855-822-6927
- **Enroll online:** www.DiscoverHighmark.com/individuals-families
- **For in-person visit:** Your local Highmark Insurance store (www.HighmarkDirect.com)
- **If you work with an insurance agent/producer:** Please call or visit him/her directly

SAVE TIME BY SIGNING UP FOR SECURE AUTOMATIC PAYMENTS:

When you sign up for e-Bill, your monthly premium payments are automatically deducted from the account you specify.

e-Bill:

- provides a quick, convenient and secure way to receive and pay your monthly premium invoices
- reduces the chances of identity theft and eliminates the need to write and send checks
- allows you to focus on the important things in life – like keeping yourself and your family healthy – instead of worrying about whether your health insurance premium has been paid for the month.

There is no fee to use e-Bill. Set up your account as soon as you receive your first invoice.
Visit **www.highmarkbcbs.com** to learn more.

GO TO STEP 5 Submission

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance or for a paper copy, call 1-855-873-4106.

STEP 5 SIGN AND SEND YOUR COMPLETED APPLICATION

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I/we understand that the Agreement is available only to residents of the geographic area in which the product for which this Application is completed is available and that this Application is subject to the provisions of this Agreement. This Agreement renews on an annual basis. **If the first payment is not made with this Application, the first premium payment is due by the due date printed on your first invoice. Failure to pay before this due date will result in your Application being canceled.** You can also pay your premium monthly in advance to Highmark. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your ongoing monthly premium payments are not received in the full amount within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your final premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark if any information I supplied on this Application changes. I must call 1-800-544-6679 to report any changes.

If your Application for other than HMO coverage is accepted, you agree to resolve any and all disputes, claims, or controversies arising out of or relating in any way to the Agreement that is issued or any service for which benefits are provided thereunder through binding arbitration rather than litigation in court. Your agreement to arbitrate applies to disputes between you and Highmark or any of Highmark's parents, subsidiaries, affiliates, officers, directors, employees, or agents. Any such disputes, claims, or controversies may only be brought individually and not in concert with other individuals who are not covered under the Agreement, unless otherwise agreed to by Highmark. Judgment may be entered on any arbitration award in any court having jurisdiction. The party filing arbitration may choose to file before JAMS, the American Arbitration Association, or any other organization or arbitrator mutually agreed to by the parties. Pennsylvania law will apply.

EFFECTIVE DATE OF COVERAGE

I/we understand/agree that, subject to the conditions of enrollment on this Application, coverage will be effective for individuals listed on this Application following receipt of the completed Application and payment in full of the first premium payment:

If you apply during:	Open Enrollment	A Special Enrollment Period (SEP)	For HIPAA or Conversion Coverage
Your effective date is:	January 1, 2019	Based upon the application laws for each eligible SEP	The Effective Date indicated on this application

To the best of my/our knowledge and belief, the information provided on this Application is true and correct.

I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of such contract.

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 & subjects such person to criminal & civil penalties.

Applicant's Signature____________________ Date __________

Spouse/Domestic Partner/Parent's Signature____________________ Date __________

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18, and applying for a policy that only covers yourself, your parent or guardian must sign.

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE APPLICANT.

APPENDIX: CHOOSE YOUR PLAN - CONVERSION OR HIPAA ONLY

Choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan. You **MUST** choose a plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark** group plan ended OR you are applying for a Health Insurance Portability & Accountability Act (HIPAA) plan to cover you from the date your last employer coverage ended.

Note: Your proposed first premium amount is based on not using tobacco products. You agree to pay any adjustment to the rate if you use tobacco products.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre*, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland

***Note:** You must reside in one of the following zip codes in Centre County to enroll in one of these plans – 16677, 16686, 16829, 16845, 16859, 16865, 16866, 16874, 16877.

I am/we are applying for **new** coverage under:

Highmark Health Insurance Company Group Number: 036000-00

☐ **Shared Cost Blue PPO Bronze 7500 –** Annual Deductible: $7,500 Individual/$15,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Allegheny, Washington, Westmoreland

I am/we are applying for **new** coverage under:

Highmark Choice Company Group Number: 058000-00

REMINDER: If you select an HMO plan, you must select a PCP in STEPS 1 and 2 for each member applying for coverage on this Application.

☐ **my Direct Blue HMO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Erie

I am/we are applying for **new** coverage under:

Highmark Choice Company Group Number: 058000-00

REMINDER: If you select an HMO plan, you must select a PCP in STEPS 1 and 2 for each member applying for coverage on this Application.

☐ **my Direct Blue Erie HMO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family

COMPLETE FOR ANY OF THE ABOVE PLAN CHOICES:

APPLICATION DUE DATE: ______________________ FIRST PREMIUM AMOUNT DUE: ______________________

Requested Effective Date of Coverage:

☐ Conversion Policy - Effective from: ______________________ Effective to: ______________________

☐ HIPAA Policy - Effective from: ______________________ Effective to: ______________________

ANSWER QUESTIONS 1 – 5 ONLY IF YOU ARE APPLYING FOR HIPAA COVERAGE.

1. If your most recent coverage offered you "COBRA" or similar continuation of coverage benefits required by the state, did you elect that coverage? ☐ Yes ☐ No If YES, have you used up all your benefits under that coverage? .... ☐ Yes ☐ No
2. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months? * ☐ Yes ☐ No

   *Here's how to find out if you have the required 18 months of prior creditable coverage: Count periods of creditable coverage that you had before any breaks in coverage. Count them only if the break in coverage was less than 63 days. Do not count days during a waiting period when you had no coverage. Do not count days in a waiting period to determine if you had a break in coverage.
3. Did your most recent health care coverage end within the last 63 days? .... ☐ Yes ☐ No
4. Did your most recent health care coverage terminate because you did not pay your premium? This includes contributions or fraud. ☐ Yes ☐ No
5. Are you attaching a copy of your "Certificate of Prior Creditable Coverage" form? .... ☐ Yes ☐ No

   If you answered "No" to question 5 above, you can still prove that you had prior coverage in one of the following ways:

   a) Send us your signed written statement about your last coverage. Include names of the plans that covered you in the last 18 months. Include the beginning and end dates of coverage. Attach copies of papers proving that you had coverage during those times. This can be a copy of an identification card or an explanation of benefits. It can also be premium invoices or pay stubs proving that you paid for health coverage. You must also cooperate with us to prove that you had coverage. - OR -

   b) Complete and send us a HIPAA Prior Coverage Disclosure and Authorization Form instead of a written statement. You can get this form by calling Member Service at 1-800-544-6679. You can also call us to establish that you had coverage. Give us as much information as you can. Sign the form to let us contact your prior plans to prove that you had coverage.

Please complete the form below.

Policy Holder Name (First, Middle, Last): ______________________

Social Security Number: ______________________

Monthly Premium for the plan you selected, based on applicants indicated on this Application: ______________________

Payment Enclosed: $ __________ Group Number (*see **bold, blue** eight-digit number; listed above plan selection*): ______________________

Failure to provide complete information in the above form may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 10.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.
Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.
如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.
Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.
한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.
Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.
Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.
إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.
Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.
Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.
Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.
Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.
Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.
Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.
日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。
اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .