Enrollment Services
PO Box 8868
Wilmington, DE 19899
866.835.8977
Fax 877.736.5708

MEMBER ENROLLMENT / CHANGE APPLICATION

Thank you for choosing Highmark Blue Cross Blue Shield Delaware as your health insurance carrier.

Attached is the Member Enrollment / Change Application.

Your employer will fill out the top portion, which includes your group number, as well as the requested effective date of your employer-based coverage.

SECTION ONE

- Reason For Application/Change. Please indicate the reason for the application/change.
- For life events (marriage, divorce or birth) you have 30 days to apply. However, in order for coverage to begin on the event date, Blue Cross Blue Shield must be notified within 10 days of the event.
- If you are choosing the Blue Care® or Blue Select® product, please be sure to include a PCP for yourself and your dependents. If your employer does not have a provider directory, there is an online provider directory on our website, www.highmarkbcbsde.com.

SECTION THREE

Health, Dental, and Vision Coverage Choices. Please be sure you indicate the plan you are selecting. Please refer to the plan choice that is indicated in the paperwork given to you by your employer.

SECTION FOUR

- Dependent Information. When submitting this application to add, cancel or change a dependent, only include the dependents that are having changes.
- If you have more than 3 dependents your employer has extra dependent sheets for you to list the additional dependents.

SECTION FIVE

Coordination of Benefits. Complete this section only if you or your dependent(s) is/are covered by another insurance policy that will remain active at the same time of this policy.

SECTION EIGHT

Please be sure to sign and date the application.

Please detach this sheet before returning this application to your employer.

www.highmarkbcbsde.com

HIGHMARK® Delaware

MEMBER ENROLLMENT / CHANGE APPLICATION

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THIS LINE IS FOR EMPLOYER USE ONLY	Group Number:	Report Code (if applicable):	Effective Date: / /	**www.highmarkbcbsde.com**

SECTION 1 REASON FOR APPLICATION / CHANGE

- ◯ New hire
- ◯ Open Enrollment
- Life event: ◯ marriage, ◯ divorce, ◯ birth; date of event : _____/_____/_____
- ◯ Other (specify):
- ◯ Coverage loss: Reason for loss: _____
- Previous carrier and ID number: _____
- Date of loss (month, day, year): _____
- List who was covered: _____

• To begin COBRA coverage, please submit your COBRA Election Form.
• Please forward a HIPAA Certificate with this application or upon receipt, if you want a review of preexisting credit.

SECTION 2 EMPLOYEE INFORMATION

Please Print First Name:	Last Name:	M.I.:	Jr., Sr.:	Social Security or Highmark DE ID Number:

Address—Apartment Number, Street:	City:	State:	Zip Code:

Home Phone: ( )	Employer Name:	Employee Number:	Department Number:

Date of Birth:	E-mail Address (optional):	Marital Status: ☐ Single ☐ Married	Gender: ☐ Female ☐ Male	Are you eligible for Medicare? ☐ Yes ☐ No

Employment status: ☐ Full-time ☐ Part-time ☐ Retiree ☐ Other (specify):	Number of hours worked per week:	Date of Hire: / /	Date of Retirement: / /

Name of your selected Primary Care Physician (PCP):	Physician's ID Number:	Is this your current PCP? ☐ Yes ☐ No

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)

SECTION 3 HEALTH, DENTAL AND VISION COVERAGE CHOICES

Choose your Health plan from those offered by the employer:	Health coverage is for: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Family	☐ Begin coverage ☐ Terminate coverage
Choose your Dental plan from those offered by the employer:	Dental coverage is for: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Family	☐ Begin coverage ☐ Terminate coverage
Choose your Vision plan from those offered by the employer:	Vision coverage is for: ☐ Self ☐ Self & Spouse ☐ Self & Child(ren) ☐ Family	☐ Begin coverage ☐ Terminate coverage

SECTION 4 DEPENDENT INFORMATION

DEPENDENT #1

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:

Dependent's relationship to you:	Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No

Dependent's Primary Care Physician:	Physician's ID Number:	Is this the dependent's current PCP? ☐ Yes ☐ No

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)

DEPENDENT #2

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:

Dependent's relationship to you:	Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No

Dependent's Primary Care Physician:	Physician's ID Number:	Is this the dependent's current PCP? ☐ Yes ☐ No

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)

DEPENDENT #3

☐ Add ☐ Cancel	☐ Male ☐ Female	Dependent's First Name, Middle Initial (last name, if different):	Date of Birth: / /	Social Security Number:

Dependent's relationship to you:	Is dependent disabled? ☐ Yes ☐ No	Is dependent a full-time student? ☐ Yes ☐ No	Is dependent eligible for Medicare? ☐ Yes ☐ No

Dependent's Primary Care Physician:	Physician's ID Number:	Is this the dependent's current PCP? ☐ Yes ☐ No

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)

SECTION 5 COORDINATION OF BENEFITS.

If you / your dependent(s) listed on this application have any other health / dental coverage that will remain active, please provide the information requested below.

List those who are covered:	Name of other health / dental insurance carrier:
Effective date of coverage (month, day, year):	Identification Number:

SECTION 6 MEDICARE-ELIGIBLE DEPENDENTS

Complete the section below or send us a copy of your Medicare card.

Your Medicare Claim Number / Health Insurance Code (HIC Number):	Dependent's Medicare Claim Number / Health Insurance Code (HIC Number):
Your hospital coverage (Part A) effective date (month, day, year):	Dependent's hospital coverage (Part A) effective date (month, day, year):
Your medical coverage (Part B) effective date (month, day, year):	Dependent's medical coverage (Part B) effective date (month, day, year):

SECTION 7 TERMS OF AGREEMENT

TERMS OF AGREEMENT . It is understood that: (1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and Highmark Blue Cross Blue Shield Delaware. (2) I certify that representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete. (3) I authorize my employer, as my agent, if applicable to collect premiums by payroll deduction, for remittance to Highmark DE, with the understanding that payment will not be complete until actually received by Highmark DE. (4) Any physician, hospital or other health care provider shall release to Highmark DE or its designee any of my and my covered dependents' protected health information for the purpose of payment, health care plan operations, or as otherwise required by law.

SECTION 8 TODAY'S DATE (month, day, year)	YOUR SIGNATURE