INSTRUCTIONS FOR COMPLETING YOUR INDEPENDENCE BLUE CROSS ENROLLMENT FORM

Please complete both sides of the form. Group Administrators/Subscribers: Both signatures are required on page 2

NOTE: See back of this page for terms and definitions.

PLEASE KEEP A COPY OF BOTH SIDES FOR YOUR RECORDS. ADDITIONALLY, A COPY CAN BE USED AS A TEMPORARY IDENTIFICATION CARD.

Please print carefully in capital letters as shown below. DO NOT USE RED INK OR PENCIL.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	0	1	2	3	4	5	6	7

Thank you for choosing IBC. In order to process your application as quickly as possible, please **read the following instructions and provide the information requested.**

Section 1: Fill out this section if you are a new or current subscriber. If you are making any changes, additions or deletions, please check the boxes that apply. Please see your Group Administrator if you are making a change to COBRA or Conversion. If you are deleting a family member, please check "Delete a Dependent" in Section 1 and indicate **only** the family member for which coverage is to terminate in Section 4.

Section 2: This section should be completed by your Group Administrator. If this is an application for a new applicant or a member changing plans, please indicate the type of coverage elected. For example, your group has Personal Choice C2F3O1, Select Drug Program 20/40/60 and $100 Vision. This would be indicated as:

PPO	HMO	POS	RX	Vision	Dental	CMM	Traditional	Security 65
C2F301			204060	100				

The Effective Date of Coverage and Terminate Contract Information should be completed by your Group Administrator.

Section 3: This section requires information about YOU, the employee. Please complete each area. If you are an HMO/POS plan member, you must choose a Primary Care Physician Office identification number from the booklets provided or by using our on-line provider directories (www.ibx.com). We cannot issue an identification card without the selection of a Primary Care Office.

Section 4: And 4A: The following sections pertain to those subscribers with dependents. If you are a single person, you may skip to section 5A. Sections 4 and 4A request information about the dependents you are adding, deleting or changing. Please provide us with the information pertaining to your spouse first and then your children, beginning with the oldest child. When deleting dependents, only indicate those dependents that are being removed from the policy.

If available, please provide the Social Security number for each dependent. If any of the listed dependents have insurance coverage in addition to IBC, please complete Section 5A. If you are adding a dependent that has a full-time student, please attach verification from an accredited educational institution where the child is enrolled full time. If you are adding a dependent that is handicapped, please contact your group administrator for a Handicapped Dependent Verification Form which should be completed and returned with your application. See Sections 5A and 5B to list any additional insurance that may cover the dependent(s).

Members of HMO/POS plans should list the Primary Care Office identification number for each member of the family.

Section 5: And 5B: This section includes important information regarding other health insurance coverage you may have for you and/or your family which will continue after you enroll in IBC. Part 5A asks you to indicate the other health insurance policy information of those family members that have Additional Insurance. If you selected "yes" to Additional Insurance in section 4 for any of the listed dependents, 5A must be completed. Part 5B asks whether you or any member of your family is eligible for Medicare benefits and for what reason.

Section 6: This section must be completed by your Group Administrator.

Section 7: ***Please sign and date your enrollment/change form. Failure to do so will delay processing of your application and coverage cannot be activated. Please Complete The Subscriber County Of Residence Section Under Your Signature.***

IMPORTANT NOTE TO GROUP ADMINISTRATORS: SECTION 6 MUST BE COMPLETED BY YOU BEFORE SUBMISSION TO IBC. ENSURE THAT BOTH SIDES OF THE APPLICATION ARE COMPLETED.

Thank you for taking the time to complete your application. We look forward to having you as a member of the IBC family!

6764 09/03

Mail Completed Application to: Independence Blue Cross, Enrollment Dept., 1901 Market Street, Philadelphia, PA 19103-1480

EXPLANATION OF TERMS

COBRA or Conversion	COBRA or Conversion coverage is offered to certain employees and their beneficiaries when their employment terminates. Please see your Group Administrator for additional information.
Contract	The agreement between IBC and your group whereby subscribers and their dependents elect IBC coverage.
Dependent	Spouse, or unmarried child of a subscriber, who meet eligibility requirements.
Group Administrator	This refers to your Employer's Benefits Manager, Human Resources Representative, Group Leader or Employer Representative.
Handicapped Dependent	An unmarried dependent child 19 years of age, or older, who, in the judgement of IBC, is incapable of self-support because of a mental or physical disability (for which continuing justification is required).
IBC	Independence Blue Cross
Life Event Change	This refers to any change in your personal circumstances which enables you to enroll in IBC outside the open enrollment period. Examples of a Life Event Change are: newborn, termination of previous coverage (must be continuous), court order that requires the subscriber to provide health care coverage for a dependent child, etc.
Member	The subscriber or dependent for whom the appropriate forms and premium payments have been received by IBC.
New Application	This applies if you have never had coverage with IBC before, or you have terminated your employment and are applying for coverage with IBC under a different employer group.
Subscriber	YOU, the employee or person who is eligible and has enrolled for coverage as the policyholder.
Termination	This is the date that a group contract expires, and/or the date that a subscriber and/or member ceases to be eligible or chooses to discontinue their coverage.

Independence Blue Cross

Universal Enrollment Form

1 Subscriber or Member Enrollment or Change — Employee MUST Complete in Full

New
- ☐ Open Enrollment
- ☐ Life Event
- ☐ New Hire
- ☐ KHPE Non-Group

Change
- ☐ Address
- ☐ Rehire
- ☐ Last Name
- ☐ Dental Office
- ☐ Primary Care Office

Life Event Change
- ☐ Marriage
- ☐ Other
- ☐ Add a Dependent
- ☐ Delete a Dependent

Life Event Date ____________________

Other Change
- ☐ COBRA

Effective Date ____________________

Effective Date of Coverage

Terminate Contract
- ☐ Terminated Employment
- ☐ Full Time to Part Time
- ☐ Deceased. Indicate date.
- ☐ Other. Please explain.

____

2A Plan (please specify co-pay or benefit option):

PPO | HMO | POS | RX | Vision | Dental

- ☐ CMM
- ☐ Traditional
- ☐ Security 65

Employment Status
- ☐ Active
- ☐ Retiree

3 Subscriber Information – Please complete this entire section, whether you are a new applicant or are making a change to an existing contract.

Social Security Number or ID Number | Last Name | First Name | M.I. | Gender M/F | Date of Birth

Street Address | Apartment or Suite | City | State | Zip Code

Telephone Number Including Area Code
- Home
- Work

Coverage Information
- ☐ Employee Only
- ☐ Employee and Child
- ☐ Employee and Spouse
- ☐ Employee and Children
- ☐ Family

Date of Hire

Primary Care Office Number

Primary Care Office Name ____________________ Check if current patient. ☐

Primary Dental Office Number

Primary Dental Office Name ____________________ Check if current patient. ☐

4 Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Spouse Last Name | First Name | M.I. | Gender | Date of Birth

Social Security Number | Primary Care Office Number | Primary Care Office Name ____________________ | Check if current patient. ☐ | Primary Dental Office Number | Check if current patient. ☐

Will other health insurance be in effect? If yes, see 5.
- Yes ☐
- No ☐

Dependent over 19? Provide verification.

Child Last Name | First Name | M.I. | Gender | Date of Birth

Social Security Number | Primary Care Office Number | Primary Care Office Name ____________________ | Check if current patient. ☐ | Primary Dental Office Number | Check if current patient. ☐

- Yes ☐
- No ☐
- Student ☐
- Disabled ☐

Child Last Name | First Name | M.I. | Gender | Date of Birth

Social Security Number | Primary Care Office Number | Primary Care Office Name ____________________ | Check if current patient. ☐ | Primary Dental Office Number | Check if current patient. ☐

- Yes ☐
- No ☐
- Student ☐
- Disabled ☐

Child Last Name | First Name | M.I. | Gender | Date of Birth

Social Security Number | Primary Care Office Number | Primary Care Office Name ____________________ | Check if current patient. ☐ | Primary Dental Office Number | Check if current patient. ☐

- Yes ☐
- No ☐
- Student ☐
- Disabled ☐

4A Dependent Information – If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? Yes ☐ No ☐

Is any dependent's last name different from yours? Yes ☐ No ☐

If you answered yes to either question, please explain.

5 Other Insurance Information

5A Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name

Policy Number

Policy Holder

Type of Benefits _____ Effective Date

5B Are you or any of your dependents currently receiving Medicare Benefits? Yes ☐ No ☐ If yes, please give details.

	Name	Medicare Number	Part A Effective Date	Part B Effective Date
Self				
Spouse				
Child				
Child				

Reason

Check all that apply.

Age ☐

Disability ☐

ESRD ☐

6 Group and Employer Information

Your Group Administrator **MUST** complete this section. Your application **CANNOT** be processed unless this section is complete.

Group Name

Group Number

Payroll/Work Location

Account Number

Employer or Group Administrator Signature

Date _____

7 Signature and Verification

Please read carefully and sign below. Your application **CANNOT** be processed without your signature. 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.

For PPO and CMM Members - By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically related facility, insurance company or other organization or institution that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliates, QCC Insurance Company, Highmark Blue Shield and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association or Welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO and POS Members - I understand that the provision of services to me and my dependents as Members of Keystone Health Plan ("Keystone") is governed by the applicable Master Group Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and, 2) I and my dependents authorize any person or organization providing services to furnish Keystone, its affiliates and ancillary service providers who are responsible for administering certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all self referred services, as specified in the contract. I further understand that i can change health plan coverage only at the time my employer and Keystone specify. Keystone POS program Self-Referred benefits may be underwritten by QCC Insurance Company. Referred benefits underwritten or administered by Keystone Health Plan East and QCC Insurance Company and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.

Employee Signature

Date _____

Subscriber's County of Residence