

# APPLICATION TO ENROLL OR CHANGE ENROLLMENT

*Dependable Health Care Coverage from the  
Capital BlueCross Family of Companies*

**GROUP ADMINISTRATOR** - You must complete all areas in the Group Administrator Box before submitting this application to Capital BlueCross.

**GROUP INFORMATION (For Group Administrator Use)** – Print the Employer’s Name, Group Name (if different from employer’s name), and Group Number/Subgroup Number assigned by Capital BlueCross. Complete the Class of the Subscriber. Indicate if the waiting period has been met. For Association Groups, print the Employer’s Address, the Member Firm ID, and the Member Firm ID Effective Date. For all groups, print the Effective Date of Coverage/Change and Date Hired. Indicate if employer employs (1) 20 or more employees, or (2) 100 or more employees, within the definition of the Medicare Secondary Payer (MSP) Laws.

**MEDICARE SECONDARY PAYER INSTRUCTIONS (For Group Administrators)** – An employer employs “20 or more employees” if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. 42 C.F.R. § 411.170(a)(2)(i); Medicare Secondary Payer Manual. An employer employs “100 or more employees” if the employer employed at least 100 employees on 50 percent or more of its regular business days during the previous calendar year. 42 C.F.R. § 411.101 (Large Group Health Plan Definition); Medicare Secondary Payer Manual. Special rules apply with respect to multi-employer group health plans. Please note that it is the **Group’s responsibility** to assure that members are enrolled correctly consistent with the Medicare Secondary Payer Laws. The MSP provisions and regulations can be found at 42 U.S.C. §1395y(b) and 42 C.F.R. Part 411 and can be found in your local law library. You can also find information at [cms.hhs.gov/home/medicare.asp](https://cms.hhs.gov/home/medicare.asp).

**TYPE OF ACTIVITY (For Group Administrator Use)** – Check the appropriate box to indicate whether the subscriber is enrolling in, changing, or terminating group coverage.

**REASON CODES (For Group Administrator Use)** – Place a check mark in the appropriate box to indicate the reason for completing the application. If the reason is due to an initial eligibility, life status change, or termination of a subscriber or subscriber’s dependent, enter the appropriate code and date the change occurred. (If multiple changes occur, use the code most applicable.) Refer to the back of the application for appropriate codes and descriptions.

**Please send the completed application to:**

**Account Administration  
Capital BlueCross  
PO Box 772612  
Harrisburg, PA 17177-2612**

# INSTRUCTION SHEET

## INSTRUCTIONS TO SUBSCRIBER

**IMPORTANT: Print Clearly** and complete this form accurately to help us process your enrollment or change information as quickly as possible. If you have any questions about completing the Enrollment/Change Form, see your Group Administrator or call Customer Service at **1.800.962.2242**.

1. **SUBSCRIBER INFORMATION** – If you are a current subscriber, clearly print your identification number as it appears on your ID card. If you are a new subscriber and do not have an identification number, print your Social Security Number as the Subscriber Identification. Print your Birth Date. Check the appropriate boxes indicating your sex and marital status. Print your Name (Last, First, Middle Initial), current Mailing Address, and provide your Home Email Address and Home/Cell and Work Phone Numbers, including Extension (required in the event Capital BlueCross needs to notify the enrollee of benefit information). Check the appropriate box for Employment Status and print the Average Number of Hours Worked Per Week. If Retired, enter the retirement start Date. If your Employment Status is not one of the choices listed, please complete the Other (Explain) field. When making only an address change, print your Subscriber Identification/Social Security Number, Name (Last, First, Middle Initial), new Mailing Address, and check the “Yes” block for “New Address.” Provide your Home/Cell Phone Number and complete section 10.

2. **ENROLLMENT/CHANGE INFORMATION** – Print the Name (First, Middle Initial, and Last Name if different from the subscriber) of all your dependents who are eligible for health care coverage and who are to be enrolled under your contract. Check the appropriate box to indicate sex of spouse and each dependent’s relationship to you. (If the dependent is other than a son or daughter, write the relationship in the space titled “OTHER”). Print the Social Security Number and the full Birth Date of each dependent. Be sure to indicate whether the dependent is being “added” or “removed” by checking the appropriate box.

If the spouse or dependent’s address is different from the Subscriber’s due to a Qualified Medical Child Support Order (QMCSO), a copy of the court order is required (along with the alternate address) to process the address change. Provide this information to your Group Administrator to submit with this application. If the address is different due to Act 150 (The Spousal and Child Medical Support Act 150 of PA), contact Customer Service (the numbers are listed on this application) so the appropriate forms may be mailed to you. Be sure to have the form notarized before returning it to us.

3. **COVERAGE SELECTION/CHANGE** – Select the coverage for which you (and/or your dependents) are applying or to which you are changing. If you are adding a product and multiple benefit levels are offered (i.e., “high,” “low,” “1,” “2”), indicate the benefit level chosen in the column. Otherwise, place an “A” to add, or “R” to remove in the column. If you are unsure which types of coverage you now have, or are eligible to add, contact your Group Administrator.

**Note:** For subscribers enrolling in *HMO* coverage, the service area limitations are listed on the back of the form. If you are eligible for Medicare coverage and intend to apply for enrollment in one of our Medicare plan options, please call 1.800.976.2242.

4. **PHYSICIAN OF CHOICE** – Physician of Choice selection requirements vary by product. The following products involve Physician of Choice selection:

- With *PPO Plus* coverage, selection of a Physician of Choice is *voluntary*, and specialty care from participating providers may be accessed directly, without a Physician of Choice referral.
- With *POS* coverage, selection of a Physician of Choice is required, and in order to obtain the highest level of benefits, the selected Physician of Choice must provide referrals for nonemergency, specialty, and other care.
- With *HMO* coverage, selection of a Physician of Choice is required, and the selected Physician of Choice must provide referrals for nonemergency, specialty and other care. Print your Physician of Choice group practice name and group Physician of Choice Code number (found in your Capital BlueCross Provider Directory or Keystone Health Plan Central Provider Directory or on our website—capbluecross.com). You and each member of your family can select his or her own Physician of Choice from the Directories or website listing. The Directory or website may indicate that the physician you wish to select is available to current patients only. If you are currently a patient of that physician, please indicate that in this section on the enrollment form. If you are not currently a patient, please select a different Physician of Choice.

5. **MEDICARE COVERAGE INFORMATION** – Complete this section only if you or your dependents are eligible for Medicare benefits. Print the Medicare Claim Number and Effective Date(s) found on your red, white, and blue Medicare Health Insurance Card. Check the box in the appropriate column under the “Reason/Effective Date for Medicare Coverage”—whether eligible for Medicare by Age; by Disability under Medicare; or by End Stage Renal Disease (ESRD). If you or your dependents are eligible due to multiple reasons, please enter the Effective Date for each reason in the applicable date field.

6. **HANDICAPPED DEPENDENTS** – List the Names of any Handicapped Dependents enrolled under your contract. If this section is completed, additional information may be sent to you.

7. **OTHER INSURANCE COVERAGE** – Complete this section if you and/or any of your dependents currently have health care coverage with another insurance company. Print the Name of each person holding the contract, the Name of the Health Care Plan or Insurance Company, and the Identification or Policy Number. If this section is completed, additional information may be sent to you.

8. **STUDENT INFORMATION** – Complete this section if any of your dependents are a full-time student at an accredited School or College/University. Print the Name of the dependent(s), the Name of the school or College/University, and the anticipated Graduation Date(s).

9. **CHANGE INFORMATION** – Complete this section to make a change in Name, Social Security Number, or Birth Date for you or a Dependent. Mark the appropriate box to indicate if the change is for you or the dependent. Print the current information in the “FROM” block and the new or correct information in the “TO” block.

10. **STATEMENT OF APPLICATION** – Read this section carefully. You must sign and date the application for it to be processed. Capital BlueCross will not accept your application if this section is not completed.

Tear off this page and use it to help you complete this form. Then discard.

## APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

**GROUP ADMINISTRATOR:** You must complete all areas in the box below before submitting this application to Capital BlueCross.

**SUBSCRIBER:** Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION															
Subscriber Identification				Birth Date		<input type="checkbox"/> Male <input type="checkbox"/> Female									
Subscriber Name (Last, First, M.I.)						<input type="checkbox"/> Single <input type="checkbox"/> Married									
Mailing Address (Include street address, city, state and ZIP Code)						New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No County									
Home Phone Number		Cell Phone Number		Work Phone Number / Ext.		Home Email Address									
Employment Status:															
<input type="checkbox"/> Active (Full-Time) <input type="checkbox"/> Retired—(Date) _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Active (Part-Time) <input type="checkbox"/> Other—(Explain) _____ <input type="checkbox"/> Salary <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union															
						Average Number of Hours Worked Per Week									
2. ENROLLMENT/CHANGE INFORMATION															
First Name & Middle Initial (Show Last Name if different from Subscriber)			Social Security Number			Birth Date			ADD or REMOVE?			Trad. Comp. PPO PPO Plus POS HMO Senior Drug Dental Vision			
SUBSCRIBER									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
<input type="checkbox"/> Son <input type="checkbox"/> Dau									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
<input type="checkbox"/> Son <input type="checkbox"/> Dau									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
<input type="checkbox"/> Son <input type="checkbox"/> Dau									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
<input type="checkbox"/> Other									<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE						
If you need an alternate address for a spouse or dependent, please see No. 2 on the INSTRUCTION SHEET.															
3. COVERAGE SELECTION/CHANGE															
4. PHYSICIAN OF CHOICE															
Indicate Practice Names & Codes (Refer to Applicable Provider Directory)															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice Code #: Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Physician of Choice selection required for POS and HMO, optional for PPO Plus.															
5. MEDICARE COVERAGE INFORMATION															
Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Please list the starting date for each reason in the applicable date field. (Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)		Name of Subscriber or Dependent		Medicare Claim Number		Effective Date(s)				Reason/Effective Date for Medicare coverage					
						Hospital (Part A)		Medical (Part B)		<input type="checkbox"/> Age		<input type="checkbox"/> Disabled		<input type="checkbox"/> ESRD	
						Effective Date:		Effective Date:		Effective Date:		Effective Date:			
6. HANDICAPPED DEPENDENTS						7. OTHER INSURANCE COVERAGE									
Name of Handicapped Dependent						Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with <b>any other</b> insurance company. If completed, you may receive additional information. (Please attach a separate sheet of paper if additional space is needed.)									
Name of Subscriber or Dependent						Name of Health Care Plan/Insurance Co.		Identification/Policy Number							
9. CHANGE THE FOLLOWING INFORMATION						8. STUDENT INFORMATION									
Change is for <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent (Name)						Complete the following information for DEPENDENTS who are enrolled as a full-time student at an accredited school or college/university. (Please attach a separate sheet of paper if additional space is needed.)									
Name From To						Student's Name		Name of School or College/University		Expected Graduation Date					
Birth Date From To															
Social Security Number From To															
10. STATEMENT OF APPLICATION															
By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.															
Subscriber's Signature _____ Date _____															

## INITIAL ELIGIBILITY:

Code	Definition
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- |     |   |
|-----|---|
| A : | New group enrollment and/or group medical only benefit change.  |
| B : | Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group. |
| C : | The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent.)                             |
| D : | The Association acquires a new employer group.  |
| E : | Union member now eligible for coverage.   |

## LIFE STATUS CHANGES (If multiple changes occur, use the code most applicable):

Code	Definition
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- |     |   |
|-----|---|
| F : | The subscriber marries.   |
| G : | The subscriber has a child, adopts, acquires a stepchild, or becomes legal guardian of a child.                             |
| H : | The subscriber divorces or legally separates and no longer has coverage through a spouse.                                   |
| I : | The subscriber has a change in employment status (i.e., from part-time to full-time, hourly to salary, union to non-union). |
| J : | The subscriber has a change in his/her Medicare Primary Status (e.g., the employee retires and Medicare becomes primary).   |
| K : | The subscriber and/or dependent loses coverage under another benefit plan.  |
| L : | The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).                    |

## SUBSCRIBER TERMINATIONS (Including all dependents):

Code	Definition
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- |       |   |
|-------|---|
| IS01: | The subscriber is no longer employed/requests cancel.               |
| IS02: | The subscriber is deceased.   |
| IS03: | The contract cancel reason is unknown.                              |
| IS05: | The subscriber has coverage with another Blue plan.                 |
| IS06: | The subscriber selected coverage through another insurance company. |

## DEPENDENT TERMINATIONS:

Code	Definition
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- |       |   |
|-------|---|
| IM01: | The dependent is deceased.                                    |
| IM03: | The dependent has coverage with another Blue plan.            |
| IM04: | The dependent has coverage through another insurance company. |
| IM05: | The dependent marries.  |
| IM06: | The dependent is over the age limit.                          |
| IM13: | The dependent is divorced.                                    |

## OTHER/EXPLANATION:

If the reason for the enrollment/change is other than listed above, please explain on the front of the application.

# STATEMENT OF APPLICATION

I hereby apply for the coverage indicated. I understand this application is subject to approval by Capital BlueCross, its subsidiaries, and/or reinsurers, and any coverage provided will be subject to the terms of the agreements and/or contracts issued to me. **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.** I verify that the information supplied by me is correct to the best of my knowledge, information, and belief.

**Rescissions Disclaimer for Statement of Attestation of Termination of Coverage:** By submitting member termination of health care coverage, the group hereby represents and warrants that the terminations comply with the Patient Protection and Affordable Care Act. Contributions of any funds for health care coverage will not be obtained from the member for any period beyond the date of termination. The contract holder is solely responsible for the termination of the member's health care coverage.

**For those applicants residing outside Keystone Health Plan® Central's (KHP Central) Service Area:** I have been offered the option of enrolling in KHP Central's Health Maintenance Organization. I understand that if my place of residence is not within KHP Central's Service Area, the majority of the care that I and my dependents receive as KHP Central members must be provided or referred by a KHP Central Physician of Choice, according to the terms of the KHP Central Certificate of Coverage. I have reviewed KHP Central's listing of primary care practices and have selected one which is sufficiently convenient to provide such care. I understand the conditions of enrollment and wish to enroll in KHP Central. KHP Central's Service Area includes the following counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.