

## 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):** Please print the Group/Employer information in the applicable boxes, including the Class ID, Effective Date, and Hire Data. Check the appropriate box to indicate the action to be taken (Enrollment, Change, or Terminate—see Reason Codes for reference). Please include the appropriate Plan ID for each product (medical, dental, vision, etc.) the employee has selected.

**REASON CODES (For Group Administrator Use):** Place a check mark in the appropriate box to indicate the reason for completing the application. (If multiple changes occur, use the code most applicable.) Refer to page 2 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**

### INSTRUCTIONS TO SUBSCRIBER

**1. SUBSCRIBER INFORMATION:** Enter the appropriate information in the applicable fields. Check the box to indicate reason(s) for submitting this Enrollment/Change request. In the Subscriber ID/SSN box enter your subscriber identification number as it appears on your ID card if you are a current subscriber, or if a new subscriber, enter your social security number (SSN). Enter your name (first, last), birth date, current mailing address, email address, and phone number. Check the appropriate box for employment status. If retired, enter the retirement start date. Check the disabled box “Yes” if you qualify for Medicare and also complete Section 4 of this application. In the PCP (Primary Care Physician)/NPI (National Provider Identifier) number box, enter your group physician of choice code number. This field is required if you are enrolling in an HMO or Gatekeeper PPO (GPPO) product. Your PCP/NPI number can be found in the Capital BlueCross Provider Directory, Keystone Health Plan® Central Provider Directory, or on our website — capbluecross.com. Please indicate whether you are a current patient of this provider. You and each member of your family can independently select a physician of choice from the directories or website listing.

**2. PLAN OPTIONS:** Check all appropriate plan boxes.

**3. ENROLLMENT/CHANGE INFORMATION:** For each of your spouse/dependent(s) check the box indicating the reason(s) for submitting this form and enter their name, social security number, relationship, and birth date. If the dependent is other than a son or daughter (i.e. legal dependent), complete Section 3e., and write the relationship in the relationship box. Check the disabled box “Yes” for any disabled dependents enrolled under your contract. If your disabled dependent(s) also qualify for Medicare, please complete Section 4 of this application. Enter your dependent’s physician of choice group code number in the PCP/NPI number box. This field is required if you are enrolling in an

HMO or GPPO product. Complete the student box for any dependent that is a full-time student at an accredited school or college/university. Select the coverage for which spouse or dependent(s) are applying or changing coverage.

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 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 number is listed on this application) so the appropriate forms may be mailed to you. Be sure to have the form notarized before returning it.

**4. MEDICARE COVERAGE INFORMATION:** Complete this section only if you or your dependent(s) are eligible for Medicare benefits. Enter 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, disability, 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.

**5. CHANGE INFORMATION:** Complete this section to make a change in name, social security number, or birth date. Check the appropriate box to indicate who the change is for.

**6. 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.

## INITIAL ELIGIBILITY:

### Code Definition

- 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: Union member now eligible for coverage.

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

### Code Definition

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

## 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 choosing CareConnect:** I have been offered the option of enrolling in CareConnect, a gatekeeper PPO. This means I must select a primary care physician and abide by referral processes for specialists to receive the highest level of coverage. I have reviewed the list of primary care practices that participate in the CareConnect gatekeeper PPO and have selected one that is sufficiently convenient to provide such care. CareConnect is available in the following counties: Cumberland, Dauphin, and Perry.

**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 that 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.

## SUBSCRIBER TERMINATIONS (Including all dependents):

### Code Definition

- 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

- 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 application.

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

<b>Group Name</b>	<b>Group Number</b>	<b>Subgroup Number</b>	<b>Class</b>	<b>Effective Date of Coverage/Change</b> ____ / ____ / ____	<b>Date Hired</b> ____ / ____ / ____
<b>REASON CODES</b> <i>(see page 2 for codes and descriptions)</i>					
<b>Enrollment</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Initial Eligibility Change: CODE _____ <input type="checkbox"/> Other <i>(please explain)</i> : _____			<b>Change of Enrollment</b> <input type="checkbox"/> Life Status Change: CODE _____		<b>Termination</b> <input type="checkbox"/> Termination: CODE _____
Date of Change ____ / ____ / ____			Date of Change ____ / ____ / ____		Date of Termination ____ / ____ / ____
Medical Plan ID	Rx Plan ID	Dental Plan ID		Vision Plan ID	

**SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 6 of this form. Subscriber information must be completed for any transaction.**

### 1. SUBSCRIBER INFORMATION *(please print clearly)*

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Subscriber's First Name		Subscriber's Last Name			<input type="checkbox"/> Male <input type="checkbox"/> Female	Subscriber's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Street Address		City	State	ZIP Code	New Address <input type="checkbox"/> Yes <input type="checkbox"/> No	County	Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work (   ) ____ - ____	Email Address
<b>Employment Status</b>	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time	<input type="checkbox"/> Retired <i>(date)</i> ____ / ____ / ____ <input type="checkbox"/> Other <i>(explain)</i> _____	<input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

### 2. PLAN OPTIONS

☐ PPO  
 ☐ PPO Plus  
 ☐ PPO Choice  
 ☐ CareConnect<sup>SM</sup> GPPO  
 ☐ HMO  
 ☐ Senior  
 ☐ Rx  
 ☐ Traditional  
 ☐ FSA  
 ☐ HSA  
 ☐ HRA  
 ☐ Dental  
 ☐ Vision

### 3. ENROLLMENT/CHANGE INFORMATION

<b>a. Spouse</b>								
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Spouse's First Name		Spouse's Last Name			<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Spouse's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx				
<b>b. Dependent</b>								
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent's First Name		Dependent's Last Name			<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Dependent's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No   Graduation Date: ____ / ____ / ____ Name of School: _____			
<b>c. Dependent</b>								
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent's First Name		Dependent's Last Name			<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Dependent's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No   Graduation Date: ____ / ____ / ____ Name of School: _____			

**3. ENROLLMENT/CHANGE INFORMATION (continued)**

Subscriber ID: \_\_\_\_\_

<b>d. Dependent</b>						
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Dependent's First Name	Dependent's Last Name		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Dependent's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No   Graduation Date: ____ / ____ / ____ Name of School: _____		
<b>e. Other</b> (see section #3 of the instructions for further guidance)						
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	Other's First Name	Other's Last Name		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Other's ID/SSN _____	Birth Date (MM/DD/YYYY) ____ / ____ / ____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP/NPI Number	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No   Graduation Date: ____ / ____ / ____ Name of School: _____		

**If you have more dependents, please attach an additional application.****4. 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 Health Insurance Card for the Medicare Claim Number and effective dates.)		
Subscriber or Dependent First Name	Subscriber or Dependent Last Name	Medicare Claim Number
Effective Date(s) Hospital (Part A) ____ / ____ / ____   Medical (Part B) ____ / ____ / ____		Reason/Effective Date for Medicare Coverage <input type="checkbox"/> Age ____ / ____ / ____ <input type="checkbox"/> Disabled ____ / ____ / ____ <input type="checkbox"/> ESRD ____ / ____ / ____
Subscriber or Dependent First Name	Subscriber or Dependent Last Name	Medicare Claim Number
Effective Date(s) Hospital (Part A) ____ / ____ / ____   Medical (Part B) ____ / ____ / ____		Reason/Effective Date for Medicare Coverage <input type="checkbox"/> Age ____ / ____ / ____ <input type="checkbox"/> Disabled ____ / ____ / ____ <input type="checkbox"/> ESRD ____ / ____ / ____

**5. CHANGE THE FOLLOWING INFORMATION**

Change is for <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependent		
Name	From: (First): _____ (Last): _____	To: (First): _____ (Last): _____
Birth Date	From: ____ / ____ / ____	To: ____ / ____ / ____
Social Security Number	From: ____ _	To: ____ _

**6. STATEMENT OF APPLICATION**   **Note: An authorized Group Administrator may sign for subscriber terminations (including all dependents).**

By signing this application, I am indicating that I have read the STATEMENT OF APPLICATION. I verify that the information given is true and correct.	
Subscriber's Signature	Date ____ / ____ / ____