



MEDICAL QUESTIONNAIRE ENROLLMENT FORM

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name			
Last Name	First Name	MI	Social Security No.	
Address				
City				
State		Zip	Home Phone	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled		Date of Full-Time Hire Mo Day Yr	Hours Worked Per Week	<input type="checkbox"/> COBRA Start Date _____ End Date _____
COBRA REASON: <input type="checkbox"/> Deceased <input type="checkbox"/> Involuntary Lay-Off Date of Event _____ <input type="checkbox"/> Left Employment <input type="checkbox"/> Other _____				

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

List ALL Dependents, Relationship to Employee and Coverage Selection	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Gender	Height	Weight	Dependent Status If Over Age 26	Product Selection		
								Med**	Vis	Den
Employee			/ /	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Spouse			/ /	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dom. Part.*			/ /	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other*			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other*			/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, Domestic Partner Affidavit, etc.) must be provided prior to enrollment. ☐ Other: _____

If you answered No to Med** under Product Selection, please list reason: _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Employee Signature **ONLY SIGN IF YOU ARE WAIVING COVERAGE** _____ Date _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

This Universal Medical Health Questionnaire is issued by Highmark Blue Shield on behalf of its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in the 21 counties of central Pennsylvania. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in the 29 counties of western Pennsylvania, 13 counties in northeast Pennsylvania, the state of West Virginia plus Washington County, Ohio, and the entire state of Delaware. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

III MEDICAL HISTORY INFORMATION

Please answer each question below as completely as possible. NOTE: Medical information disclosed in this section will not be used to determine the eligibility of you and/or your dependents to enroll in the coverage requested. If you or any of your dependents EVER had or CURRENTLY have any of the conditions listed below, please check all numbers and circle the specific condition(s) that apply.

Then, in the Explanation section below, please give details for all diagnosis circled in questions 1 -27. Attach additional sheets if necessary.

- ☐ 1. Cancer, Leukemia, Tumor or Cyst
- ☐ 2. Heart Surgery (Angioplasty, Stent or Bypass), Heart Disease, Implanted Pace Maker or Defibrillator, Irregular Heartbeat, Heart Murmur, Heart Regurgitation, Chest Pain, Congestive Heart Failure or Mitral Valve Prolapse
- ☐ 3. Vasculitis or Peripheral Vascular Disease
- ☐ 4. High Blood Pressure, and/or High Cholesterol
- ☐ 5. Emphysema, COPD, Cystic Fibrosis, Asthma or Allergies
- ☐ 6. Sleep Apnea, or Disease of the Throat, Ears, Nose, Sinuses or Eyes (except glasses)
- ☐ 7. Ulcerative Colitis, Crohn's, Diverticulitis, Stomach Ulcers, Acid Reflux, GERD, Hernia, Gallbladder or Rectal Disorders
- ☐ 8. Diabetes Type I or II
- ☐ 9. Hypothyroid, Hyperthyroid, Goiter, Pituitary, Pancreas or Glandular Disorders or Disorders requiring Growth Hormones
- ☐ 10. Hepatitis (please circle type): A, B, C, or Autoimmune Hepatitis
- ☐ 11. Bladder, Kidney, Prostate, Testicular, Uterine, Kidney Failure or Dialysis, Abnormal PAP in the last 5 years or Breast Condition
- ☐ 12. Any female to be covered currently Pregnant? Due Date _____. If yes, how many fetuses (single, twins, triplets, etc.). If pregnant, please give details including any complications
- ☐ 13. Arthritis (Osteo, Rheumatoid or Other), Joint Replacement, Joint Pain, Lupus, Fibromyalgia, Fractures or Limb Loss
- ☐ 14. Neck or Back Pain, Disorders of the Spine or Disc Herniation/Bulging
- ☐ 15. Head or Spinal Injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis
- ☐ 16. Any blood disorder such as Anemia or Hemophilia
- ☐ 17. Aneurysm (Aortic or Cerebral), Blood Clot, TIA or Stroke
- ☐ 18. AIDS, HIV, Chronic Fatigue Syndrome, any Immune Suppressed Illness
- ☐ 19. Depression, Anxiety, ADD, ADHD, Psychotic Disorder
- ☐ 20. Any Drug or Alcohol Problems
- ☐ 21. Any Stem Cell or Organ Transplant (planned, recommended or already performed)
- ☐ 22. Cigarette or Tobacco use?
- ☐ 23. Any hospitalizations in the last 5 years (Please give full details below)
- ☐ 24. Any acute illness (e.g., Covid-19, Pneumonia, etc.) leading to a hospitalization and/or ongoing treatment
- ☐ 25. Any future surgeries discussed, planned or recommended (Please give full details below)
- ☐ 26. Currently taking any prescription medications? Please give details below to include the name of the medication and condition for which the medication is needed.
- ☐ 27. Are there any other medical conditions not listed above? (Please give full details below)
- ☐ 28. In the last five years have you been treated (including medication) for, diagnosed with, or sought treatment from a member of the medical profession for : Macular Degeneration, Retinitis Pigmentosa, Retinopathy?

IV EXPLANATION SECTION

Provide an explanation for each box marked in questions 1 - 28. Any prescription medications that are not in response to the questions above - please list prescription medication and the reason for the medication. If additional space is needed, please attach additional sheets. When completing the application, please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe that you or your dependent(s) may be at risk.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Medications	Date of most recent inpatient stay		Is ongoing treatment required?	If yes, please explain
						From	To		
								<input type="checkbox"/> Yes <input type="checkbox"/> No	
								<input type="checkbox"/> Yes <input type="checkbox"/> No	
								<input type="checkbox"/> Yes <input type="checkbox"/> No	

V IMPORTANT: EMPLOYEE/APPLICANT SIGNATURE (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

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

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.

Employee
Signature:

Print
Employee Name:

Date:

Discrimination is Against the Law

The Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer:

- 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 Claims Administrator/Insurer 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>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع و النطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：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。ID カードの裏に明記されている番号に電話をおかけください（TTY：711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.