INDIVIDUAL PRODUCT ENROLLMENT AND CHANGE FORM

Complete this application in blue or black INK. DO NOT USE A PENCIL OR A HIGHLIGHTER.

Group #	**HIPAA/GINA COMPLIANT**

Social Security Number (use boxes below)	Applicant's Last Name	First Name	MI
	If applicant is under age 18, parent/guardian must complete the section inside		

Applicant's Email Address	Effective Date

Street Address (PO Box Number NOT Acceptable) Must be a WV resident	City	State WV	Zip	County
Mailing Address (If different than Street Address)	City	State WV	Zip	County

Birth date Month / Day / Year	Phone Number(s)	Gender	Marital Status	Date Married Month / Day / Year
	Home (______)________________	❑ M	❑ Single ❑ Widowed	
	Day (______)________________	❑ F	❑ Married ❑ Divorced	

COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	Birth date Mo/Da/Yr	Gender M/F	Last Name	First Name	Social Security #	Dependent Age Limit 26
Legally Recognized Spouse						
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Check if Dependent is disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Check if Dependent is disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Check if Dependent is disabled

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other.

COVERAGE INFORMATION

Type of Contract: ❑ Single ❑ Adult & Child ❑ Two Adults ❑ Adult & Child(ren) ❑ Family

Benefit Selection:						
	SUPER BLUE PLUS 2008	❑ $500	❑ $1,000	❑ $1,500	❑ $2,500	❑ $5,000
	HIGH DEDUCTIBLE HEALTH PLAN	Individual	❑ $3,000	❑ $5,000		
	(must review with Sales office)	Family	❑ $6,000	❑ $10,000		
	SIMPLY BLUE	❑ $1,000	❑ $2,000			

Maternity Rider (You must check one of the boxes) ❑ Yes ❑ No *There is an additional cost for this benefit rider.
The maternity rider can only be added at initial enrollment or at the renewal and can be changed once during the life of the contract.

REASON FOR COMPLETION: ❑ New Enrollee ❑ Conversion (see below) ❑ Changes (see below) ❑ Cancel
❑ Transfer from BCBS of (List City & State):

DEPENDENT CHANGES		OTHER CHANGES
Add dependents due to	**Drop** dependents due to:	❑ New Name ❑ Change of Coverage
❑ Birth ❑ Adoption	❑ Divorce ❑ Death ❑ Other	❑ New Address ❑ Other________________
Date of Above Event: / /	Date of Above Event: / /	Date of Above Event: / /

YOUR PRIOR GROUP OR INDIVIDUAL HEALTH INSURANCE COVERAGE AND MEDICARE

LIST ALL GROUP and/or INDIVIDUAL COVERAGES YOU OR ANY OF YOUR ENROLLING DEPENDENTS HAVE HAD DURING THE PAST 18 MONTHS.
OR CHECK HERE ❑ FOR NO COVERAGE (Please continue with HIPAA eligibility section)

Name(s) of Covered Person(s)	Name of Other Insurance Co.	Policy Number	Effective Date	Cancel Date	Coverage	Type
					❑ Medical ❑ Dental	❑ Group ❑ Individual
					❑ Medical ❑ Dental	❑ Group ❑ Individual

REASON FOR CANCELING Most Recent Coverage:

The above section can be used by Highmark WV in lieu of Certificate of Coverage and will be used, in part, as the basis in determining the pre-existing condition waiting period. If applicable, Highmark WV may require other documentation such as Certificate of Coverage, EOB's, etc. in determining pre-existing condition waiting periods. YOU have a right to demonstrate creditable coverage and to request a Certificate of Coverage from a prior carrier. We will provide assistance if you cannot obtain a Certificate of Coverage from your prior carrier.

HIPAA ELIGIBILITY Answer "YES" or "NO" to the following questions by checking the appropriate box.

	Y	N
a. Have you had creditable coverage for the past eighteen (18) months without more than a sixty-two (62) day break in coverage? If YES, complete the "Your Prior Group or Individual Health Coverage and Medicare" section above, listing Name of Covered Person, etc.	❑	❑
b. Was your most recent creditable coverage with a group health plan? If YES, list the insurance carrier___________________________	❑	❑
c. Was your most recent coverage terminated because of fraud or non-payment of premiums?	❑	❑
d. Are you/dependents eligible for COBRA or currently covered through COBRA? If YES, START Date__________END Date__________	❑	❑
e. Are you eligible for coverage under another group's health plan? If YES, list the insurance carrier_______________________________	❑	❑
f. Are you eligible for coverage under Medicare or Medicaid?	❑	❑
g. Are any of your covered dependents eligible for coverage under Medicare or Medicaid? If YES, please list_____________________	❑	❑
h. Do you have other health insurance coverage?	❑	❑

In accordance with applicable law, Highmark WV will guarantee access to individual insurance if you have had at least 18 months of continuous creditable coverage without a sixty-two (62) day lapse in such coverage AND you are not eligible for group coverage, Medicare, or Medicaid AND you do not have other health insurance coverage AND you have elected and exhausted any COBRA or state continuation coverage AND your most recent coverage did not terminate due to premium lapse or fraud AND your most recent coverage was group sponsored. If you do not meet all the preceding criteria, you may be denied coverage based on medical screening.

MEDICAL HISTORY INFORMATION

If you are an enrollee who is new, converting, transferring in, or adding a dependent, you must complete the medical history questions below. All questions must be marked YES or NO. IF THE ANSWERS ARE INCOMPLETE, THE APPLICATION WILL BE RETURNED WHICH MAY RESULT IN A DELAY IN ISSUANCE OF COVERAGE. 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 you may be at risk. Completion of this Medical History Section is not a guarantee of acceptance.

YOUR HEIGHT (ft./in.) ___________ YOUR WEIGHT (lbs.) ___________ SPOUSE'S HEIGHT (ft./in.) ____________ SPOUSE'S WEIGHT (lbs.) ___________

CHECK YES OR NO AND EXPLAIN IN EXPLANATION SECTION ON THE NEXT PAGE ALL MEDICAL CONDITIONS AND DISEASES LISTED BELOW FOR WHICH YOU OR ANY OF YOUR DEPENDENTS NOW HAVE OR EVER BEEN DIAGNOSED, TREATED, OR COUNSELED:

1. Benign Conditions	**Y**	**N**
Tumor Cyst, or Growth	❑	❑
If yes, list site_________________________		

2. Cancerous Conditions	**Y**	**N**
Skin Cancer	❑	❑
If yes, list type________________________		
Other Cancers	❑	❑
If yes, list site_________________________		

3. Heart/Lung	**Y**	**N**
Anemia	❑	❑
Aneurysm	❑	❑
Angina	❑	❑
Congenital Heart Disease	❑	❑
Congestive Heart Failure	❑	❑
Coronary Artery Disease	❑	❑
Heart Attack	❑	❑
Hemophilia	❑	❑
Hypertension	❑	❑
Irregular Heart Beat	❑	❑
Stroke	❑	❑
Thrombophlebitis	❑	❑
Valvular Disease	❑	❑
Apnea	❑	❑
Asthma	❑	❑
COPD	❑	❑
Chronic Bronchitis	❑	❑
Cystic Fibrosis	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑

4. Heart/Lung Treatments	**Y**	**N**
Angioplasty	❑	❑
Bypass Surgery	❑	❑
Cardiac Catherization	❑	❑
Heart Valve Replacement	❑	❑
Pacemaker Implant	❑	❑

5. Immune System Conditions	**Y**	**N**
AIDS	❑	❑
ARC-AIDS Related Complex	❑	❑
HIV Positive Status	❑	❑
Kaposi's Sarcoma	❑	❑
Systemic Lupus	❑	❑

6. Renal	**Y**	**N**
Dialysis	❑	❑
Other Kidney Diseases	❑	❑
Renal Failure	❑	❑

7. Digestive System Conditions	**Y**	**N**
Cirrhosis of Liver	❑	❑
Colostomy	❑	❑
Crohn's Disease	❑	❑
Diabetes Type I____ Type II____	❑	❑
Diverticulitis	❑	❑
Hepatitis Type A___ B___ C___	❑	❑
Pancreatic Disorder	❑	❑
Ulcerative Colitis	❑	❑
Ulcer Reflux/GERD	❑	❑

8. Neurologic Conditions	**Y**	**N**
Alzheimer's	❑	❑
Cerebral Palsy	❑	❑
Down's Syndrome	❑	❑
Epilepsy	❑	❑
Herniated/Degenerative Disc	❑	❑
Multiple Sclerosis	❑	❑
Myasthenia Gravis	❑	❑
Paralysis	❑	❑
Parkinson's	❑	❑
Spina Bifida Cystica____ Occulta____	❑	❑
Spinal Disorders	❑	❑
Other Neurologic	❑	❑

9. Psychological	**Y**	**N**
Adjustment Reaction	❑	❑
Anorexia/Bulimia	❑	❑
Attempted Suicide	❑	❑
Depression	❑	❑
Drug/Alcohol Abuse	❑	❑
Psychosis	❑	❑

10. Muscular/Skeletal	**Y**	**N**
Amputation	❑	❑
Back Strain/Sprain	❑	❑
Fractures (list site below)	❑	❑
Site_________________________		
Joint Replacement	❑	❑
Marfans Syndrome	❑	❑
Muscular Dystrophy	❑	❑
Arthritis	❑	❑
Rheumatoid____ Osteo____		
Osteoporosis	❑	❑

11. Reproductive	**Y**	**N**
Abnormal PAP	❑	❑
Benign Prostatic Hypertrophy (BPH)	❑	❑
Endometriosis	❑	❑
Infertility: In Vitro or GIFT	❑	❑
Infertility treated w/meds	❑	❑
Pregnancy (list due date)	❑	❑
Due Date___/___/___		
Prostatitis	❑	❑
Sexually Transmitted Diseases	❑	❑
Other Reproductive	❑	❑

ANY QUESTIONS BELOW ANSWERED WITH A "YES" MUST BE EXPLAINED IN THE EXPLANATION SECTION	Y	N
12. Do you or any of your dependents use Cigarettes or Tobacco? If yes, please note in the explanation section the type of product and usage each day.	❑	❑
13. Have you or any of your dependents ever had or been advised to have an organ or bone marrow transplant?	❑	❑
14. Do you or any of your dependents have any other medical conditions not listed above that have been diagnosed or treated by a health care provider?	❑	❑
15. Have you or any of your dependents been hospitalized or had surgery within the past FIVE years?	❑	❑
16. Have you or any of your dependents been advised to have surgery which has not been performed yet?	❑	❑
17. Do you or any of your dependents have a scheduled office visit to a health care provider?	❑	❑
18. Are you or any of your dependents CURRENTLY taking prescription medications? If yes, please list patient's name, name of medication, dosage, and the reason taking the medication in the Explanation Section.	❑	❑
19. Have you or any of your dependents been treated by a health care provider or been prescribed medication during the THREE YEARS prior to your proposed effective date?	❑	❑
20. Have you or any of your dependents ever been covered by Worker's Compensation, Disability, or Subrogation for any of the conditions listed in the Medical History Section?	❑	❑

EXPLANATION SECTION

PROVIDE AN EXPLANATION FOR EACH QUESTION MARKED "YES" ON QUESTIONS 1–19 IN THE "MEDICAL HISTORY INFORMATION" SECTION. ATTACH ADDITIONAL SHEETS IF NEEDED.

Question #	Patient Name	Hospitalization Date(s)	Treatment Dates From/To	Diagnosis, Treatment, Prognosis, and Medications/Dosages

CHILD ADDENDUM (Please complete if applicant is under 18 years of age.)

Parent/Guardian: I understand that the parent/guardian signing the application is the Certificate of Policy owner, and will receive all premium invoices and a copy of the schedule of benefits as proof of purchase and is responsible for all premium payments. I understand that the child is under the primary insured and that the Certificate Booklet of Policy and ID cards will be sent to the child's address. I further understand that the Certificate of Policy owner must give permission for any changes affecting the Certificate or Policy contract including but not limited to changes in benefits, deductibles, and coinsurance.

Parent/Guardian's Social Security Number ______________________________

Guardian's Relationship to Child ____

Address and Phone # of Parent/Guardian if different from child:

Street____ City ____________________________ State______________ Zip____________

Phone____

IMPORTANT: APPLICATION FOR COVERAGE

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or recision of coverage and may subject me to legal action by Highmark WV. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Highmark WV unless and until this Application for coverage is approved and I have been provided with an Effective Date and Group Number, and only as long as I continue to qualify under the terms of this policy contract with Highmark WV, including timely payment of premiums.

If applicable, I understand that unless I or my dependents qualify as "Eligible Individuals," as that term is defined by the Health Insurance Portability and Accountability Act of 1996, that this Highmark WV coverage will not pay for any loss incurred during the first twelve (12) months after the effective date for any condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period prior to the enrollment date of coverage.

I also understand and agree that if any changes in my health status occur prior to the effective date, I will promptly notify Highmark WV.

This enrollment form conforms to the Genetic Information Nondiscrimination Act of 2008 (GINA) requirements.

Applicant's Signature ____ Date __________________________
or Guardian's if applicant is under age 18

I certify that I understand the contents of this application and the information stated herein is true and correct and I will notify Highmark WV of any changes.

Agent's Name (Please Print)__________________________Signature ____________________Phone ________________

Agent's Email Address____ Agent's Number__________________________

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
Info RQ Date	Membership Received Date (2)	On INSINQ
Memb Rec RQ Date		Inquiry Closed
Completed or Closed	Date On System	ID Mailed

Date Approved ____________________________________

Approved By ____________________________________

Date Denied ____________________________________

Coverage Effective Date ____________________________________

INSINQ Inquiry Number ____________________________________

Send to:

HIGHMARK WV

ATTN: Sales Department

P.O. Box 1948

Parkersburg, WV 26102

Highmark Blue Cross Blue Shield West Virginia is an independent licensee of the Blue Cross and Blue Shield Association