GROUP PRODUCT ENROLLMENT AND CHANGE FORM WITH DENTAL

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

HIPAA/GINA COMPLIANT

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental Application from your Group Administrator

Social Security Number (use boxes below)	Group Number	Group Name	Effective Date	Dept. Code

Level of Benefits Applied for: ❑ Medical Only ❑ Dental Only ❑ Medical & Dental **Dental only applicable for 10+ sized groups

REASON FOR COMPLETION: ❑ New Enrollee ❑ Changes (see below) ❑ Cancel (see below) ❑ Re-enrollment
❑ COBRA Start Date___________________ ❑ COBRA End Date ___________________ (see below)

DEPENDENT CHANGES
Add dependents due to:
❑ Birth ❑ Marriage ❑ Adoption
Date of Above Event_____________________

Drop dependents due to:
❑ Divorce ❑ Death ❑ Other________
Date of Above Event_____________________

OTHER CHANGES:
❑ New Name
❑ New Address
❑ Change to Medicare Eligible
❑ Change Coverage
❑ Other _____________________________
Date of Above Event____________________

CANCEL/COBRA REASON:
❑ Deceased
❑ Left Employment
❑ Involuntary Lay-Off
❑ Other Coverage
❑ Other _____________________________
Date of Above Event____________________

Applicant's Last Name (Please Use the Boxes) First Name MI

Street Address	City	State	Zip	County

Mailing Address (if different than Street Address)	City	State	Zip	County

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

Employment Status	Date of Full-Time Hire (Mo / Da / Yr)	Hours Worked Per Week	Job Title
❑ Active ❑ Retired ❑ COBRA			

COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	Birth date Mo/Da/Yr	Gender M/F	Last Name	First Name	Social Security #	Dependent Status If Over Age 26
SPOUSE						
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled

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

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S).

I HEREBY DECLINE MEDICAL COVERAGE
❑ For myself
❑ For myself and all family members
❑ For family members only
❑ For the following person(s)_______________________________

REASON FOR DECLINING COVERAGE:
❑ Have not met employer's eligibility
❑ Insured under spouse's contract with the following insurance carrier_______________________________
❑ Other_______________________________

I HEREBY DECLINE DENTAL COVERAGE
❑ For myself
❑ For myself and all family members
❑ For family members only
❑ For the following person(s)_______________________________

REASON FOR DECLINING COVERAGE:
❑ Have not met employer's eligibility
❑ Insured under spouse's contract with the following insurance carrier_______________________________
❑ Other_______________________________

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 special enrollment occurs before coverage will be offered. Any pre-existing conditions specified in the contract will apply.

Signature _______________________________ 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 coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, 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.

STOP HERE IF DECLINING COVERAGE FOR YOURSELF

ABOUT YOUR UNIVERSAL MEDICAL APPRAISAL FORM

If applicable, did you complete the Universal Medical Appraisal Form for all enrolled dependents? ❑ Yes ❑ No ❑ N/A
If you answered NO, please provide a complete Universal Medical Appraisal Form.
If you answered YES, have there been any changes to the medical histories previously provided? ❑ Yes ❑ No
If Yes, please provide an updated Universal Medical Appraisal Form for all enrolled dependents.

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Please list any previous coverage for you or any of your dependents for the past 18 months. Indicate effective and cancel dates. If the coverage listed will not be cancelled, but will coordinate coverage as a primary or secondary payor, please indicate by checking the appropriate box.

Name(s) of Covered Person(s)	Name of Other Insurance Co.	Policy Number	Effective Date	Cancel Date	Coverage Type(s)
					❑ Medical ❑ Prescription Drug ❑ Previous ❑ Primary/Secondary
					❑ Medical ❑ Prescription Drug ❑ Previous ❑ Primary/Secondary

REASON FOR CANCELING MOST RECENT COVERAGE:

The above section can be used by Highmark WV in lieu of Certificate of Creditable 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 Creditable 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 Creditable Coverage from a prior carrier. We will provide assistance if you cannot obtain a Certificate of Creditable Coverage from your prior carrier.

Medicare Information - Check the appropriate boxes and fill in all information for you and any dependents who are covered by Medicare.

❑ You	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑
❑ Spouse	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑
❑ Dependent	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑

Check this box for each individual who is receiving treatment for end-stage renal disease.

ADDITIONAL INFORMATION

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 the Group continues to qualify under the terms of the Group contract with Highmark WV, including timely payment of premiums.

I acknowledge that dependents age 19 and older may not be eligible for coverage if the dependent has other coverage available to him or her and the group plan qualifies as a "Grandfathered Plan" under federal law. For purposes of determining if the dependent is eligible under this plan, I agree to notify Human Resources by this application, or by other means should the situation change subsequent to the filing of this application.

If applicable, I understand that unless I or my dependents have twelve (12) months of Creditable Coverage, as defined by the Health Insurance Portability and Accountability Act of 1996, this coverage will not pay for any loss incurred during the first twelve (12) months after the earlier of the effective date of this coverage or the 1st day of a waiting period, 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 earlier of the effective date of this coverage or the 1st day of a waiting period. Please see your health care certificate for a more detailed explanation. This pre-existing condition exclusion period will be reduced by any days of Creditable Coverage that occurred before a "Significant Break in Coverage" defined as a period of sixty-three (63) consecutive days during all of which the individual does not have any Creditable Coverage. Pre-existing condition exclusions will generally not apply to individuals under the age of 19.

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

Applicant's Signature ______________________________ Date ____________________

Send to: HIGHMARK BLUE CROSS BLUE SHIELD WV, 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