

# Application for Group Coverage

Thank you for applying for coverage from Independence Blue Cross (IBC).  
Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Your Group Administrator must complete section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

|       |       |       |       |        |        |       |             |                 |
|-------|-------|-------|-------|--------|--------|-------|-------------|-----------------|
| PPO   | HMO   | POS   | RX    | Vision | Dental | CMM   | Traditional | MedigapSecurity |
| _____ | _____ | _____ | _____ | _____  | _____  | _____ | _____       | _____           |

3. Provide information about your spouse and dependents only if they are also applying for coverage (Section 4). If you need additional space, attach a separate sheet with your signature and date. Important: You must include a Relationship Code (listed at the bottom of page 2) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Section 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 4. Once you have completed and signed your application, be sure to make a copy for your records. Mail your application to or have your Group Administrator mail your paperwork to:

Independence Blue Cross  
P.O. Box 8240  
Philadelphia, PA 19101-8240

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684, Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the IBC family!



# Universal Enrollment Form

## SECTION 1 – Subscriber or member enrollment or change – Employee MUST complete in full

|  |   |  |  |
|--|---|--|--|
| New<br><input type="checkbox"/> Open enrollment<br><input type="checkbox"/> Life event<br><input type="checkbox"/> New hire<br><input type="checkbox"/> KHPE non-group | Change<br><input type="checkbox"/> Address <input type="checkbox"/> Rehire<br><input type="checkbox"/> Last name <input type="checkbox"/> Dental office<br><input type="checkbox"/> Primary care office | Life event change<br><input type="checkbox"/> Marriage<br><input type="checkbox"/> Add a dependent<br><input type="checkbox"/> Delete a dependent<br><input type="checkbox"/> Other<br>Life event date _____ | Other change<br><input type="checkbox"/> COBRA<br>Effective date _____<br>Effective Date of Coverage _____ |
|--|---|--|--|

## SECTION 2: To be completed by Group Administrator

|   |  |   |  |
|---|--|---|--|
| Plan (please specify copay or benefit option):<br>PPO                      HMO                      POS<br>_____<br>RX                      Vision                      Dental<br>_____ | <input type="checkbox"/> CMM<br><input type="checkbox"/> Traditional<br><input type="checkbox"/> MedigapSecurity | Employment Status:<br><input type="checkbox"/> Active<br><input type="checkbox"/> Retiree | Terminate contract<br><input type="checkbox"/> Terminated employment<br><input type="checkbox"/> Full-time to part-time<br><input type="checkbox"/> Deceased. Indicate date.<br>_____<br><input type="checkbox"/> Other. Please Explain<br>_____ |
|---|--|---|--|

## SECTION 3: Subscriber information – please complete this entire section, whether you are a new applicant or are making a change to an existing contract

|                                      |  |                |                                 |  |              |
|--------------------------------------|--|----------------|---------------------------------|--|--------------|
| Social Security Number or ID number  |  | Last name      |                                 | Middle initial   | First name   |
| Gender M/F                           | Date of birth  | Street address |                                 |  | Apt or suite |
| City                                 |  | State          | Zip code                        | Date of hire   |              |
| Telephone number including area code | Coverage information   |                | Primary Care Office ID number   | Primary Care Office name   |              |
| Home                                 | <input type="checkbox"/> Employee and child<br><input type="checkbox"/> Employee and children<br><input type="checkbox"/> Employee only<br><input type="checkbox"/> Employee and spouse<br><input type="checkbox"/> Family |                | Primary Dental office ID number | Primary Dental Office name   |              |
| Work                                 |  |                |                                 | <input type="checkbox"/> Check if current patient<br><input type="checkbox"/> Check if current patient |              |

## SECTION 4 – Family information (if applying)\*

|  |   |                        |   |                     |
|--|---|------------------------|---|---------------------|
| Spouse name: Last, First, Middle Initial                 |   | Social Security Number |   |                     |
| Employer name  | Birth date (mm/dd/yy)                                       | Age                    | Gender:   | Relationship Code:‡ |
|  | ____/____/____  |                        | <input type="checkbox"/> M <input type="checkbox"/> F |                     |
| Primary care office/ PCP name (HMO/DPOS only)†           | Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only)† |                        |   |                     |
| Current patient of PCP? (HMO/DPOS only)†                 | Primary Dental Office ID#                                   |                        |   |                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |   |                        |   |                     |

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website [www.ibx.com/findadoctor](http://www.ibx.com/findadoctor) to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).

\* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

‡Relationship Codes:

- 18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)
- 01 = Spouse
- 09 = Adopted Child
- 10 = Foster Child
- 17 = Stepson or Stepdaughter
- 19 = Child
- 31 = Court Appointed Guardian

\*.RC09.\*



**SECTION 4 — Family information (continued)\***

|  |   |                        |  |                                 |
|--|---|------------------------|--|---------------------------------|
| Dependent <sup>††</sup> name: Last, First, Middle Initial  |   | Social Security Number |  |                                 |
| Relationship (e.g., son, stepdaughter)   | Birth date (mm/dd/yy)<br>____/____/____                                 | Age                    | Gender:<br><input type="checkbox"/> M <input type="checkbox"/> F | Relationship Code: <sup>‡</sup> |
| Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>   | Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup> |                        |  |                                 |
| Current patient of PCP? (HMO/DPOS only) <sup>†</sup><br><input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Dental Office ID#   |                        |  |                                 |

|  |   |                        |  |                                 |
|--|---|------------------------|--|---------------------------------|
| Dependent <sup>††</sup> name: Last, First, Middle Initial  |   | Social Security Number |  |                                 |
| Relationship (e.g., son, stepdaughter)   | Birth date (mm/dd/yy)<br>____/____/____                                 | Age                    | Gender:<br><input type="checkbox"/> M <input type="checkbox"/> F | Relationship Code: <sup>‡</sup> |
| Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>   | Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup> |                        |  |                                 |
| Current patient of PCP? (HMO/DPOS only) <sup>†</sup><br><input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Dental Office ID#   |                        |  |                                 |

|  |   |                        |  |                                 |
|--|---|------------------------|--|---------------------------------|
| Dependent <sup>††</sup> name: Last, First, Middle Initial  |   | Social Security Number |  |                                 |
| Relationship (e.g., son, stepdaughter)   | Birth date (mm/dd/yy)<br>____/____/____                                 | Age                    | Gender:<br><input type="checkbox"/> M <input type="checkbox"/> F | Relationship Code: <sup>‡</sup> |
| Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>   | Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup> |                        |  |                                 |
| Current patient of PCP? (HMO/DPOS only) <sup>†</sup><br><input type="checkbox"/> Yes <input type="checkbox"/> No | Primary Dental Office ID#   |                        |  |                                 |

**SECTION 5: Dependent Information — If you listed dependents, you MUST answer these questions.**

|  |   |
|--|---|
| Do any dependents listed live at another address?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | If you answered yes to either question, please explain.<br>_____<br>_____ |
| Is any dependent's last name different from yours?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website [www.ibx.com/findadoctor](http://www.ibx.com/findadoctor) to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).  
<sup>††</sup> Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.  
 \* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

<sup>‡</sup>Relationship Codes:  
 18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)  
 01 = Spouse  
 09 = Adopted Child  
 10 = Foster Child  
 17 = Stepson or Stepdaughter  
 19 = Child  
 31 = Court Appointed Guardian



## SECTION 6: Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

|                        |                  |                |
|------------------------|------------------|----------------|
| Insurance Company Name | Policy Number    |                |
| _____                  | _____            |                |
| Policy Holder          | Type of benefits | Effective date |
| _____                  | _____            | _____          |

Are you or any of your dependents receiving Medicare Benefits?  Yes  No

| Name   | Medicare Number | Part A Effective Date | Part B Effective Date | Reason   |
|--------|-----------------|-----------------------|-----------------------|--|
| Self   | _____           | _____                 | _____                 | Check all that apply<br><input type="checkbox"/> Age<br><input type="checkbox"/> Disability<br><input type="checkbox"/> ESRD |
| Spouse | _____           | _____                 | _____                 |  |
| Child  | _____           | _____                 | _____                 |  |
| Child  | _____           | _____                 | _____                 |  |

## SECTION 7: Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

|   |              |                           |
|---|--------------|---------------------------|
| Group name                                | Group number | Payroll/<br>Work Location |
| _____                                     | _____        | _____                     |
| Employer or Group Administrator signature | Date         | Account number            |
| _____                                     | _____        | _____                     |

Your application cannot be processed without your signature.

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.

**For PPO members:** By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliates, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administering certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

**For HMO and DPOS members:** I understand that the provision of services to me and my dependents as members of Keystone Health Plan ("Keystone") is governed by the applicable master group contract, which provides that: 1) Except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and, 2) I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administering certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review. I understand that if I chose a Direct Point of Service product (DPOS) I will be subject to applicable deductible, coinsurance, and other copayments for all self-referred services as specified in the contract. I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_  
Subscriber's County of Residence \_\_\_\_\_

\*.RC09.\*

