

2017 Application for Small Employer Coverage

Instructions:

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

1. Carefully review and complete each section by printing clearly in **black ink**.
2. Provide information about your spouse, domestic partner, and dependents if they are also applying for coverage (Section C). If you need additional space, please complete an additional application and mail it along with your primary application.

Important: You must include a Relationship Code (listed at the bottom of page 4) to indicate your relationship to each person covered under the plan.

3. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section I) on page 7. Once you have completed and signed your application, be sure to make a copy for your records.
4. Your Group Administrator must complete the box on page 3 before your application can be processed. Applications can be mailed 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 Independence Blue Cross family!

For employer Group Administrator to complete.

Group Name: _____

Member Effective Date: _____

Group # (medical): _____

Group # (dental): _____

Group # (vision): _____

Group Administrator signature: _____

Application/Change form for Small Employer Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans*

Thank you for choosing Independence Blue Cross. In order to process your application as quickly as possible, please refer to the instructions on page 1 and provide the information requested.

SECTION A — Plan selections

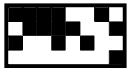
Type of coverage	Change	Reason for application	Other change
Employee only	Address	Add spouse/domestic partner	COBRA
Employee and child	Last name	Add a dependent	Effective date
Employee and children	Primary care office	Delete a dependent	Effective date of coverage ____/____/____ mm dd yy
Employee and spouse or domestic partner	Rehire	Other	
Family	Primary dental office	Life event date: (mm/dd/yy) ____/____/____	

Choice of Plan		
<p>Keystone Health Plan East Plans:¹</p> <p>HMO Platinum Preferred \$10/\$20/\$100</p> <p>HMO Platinum Preferred \$20/\$40/\$150</p> <p>HMO Gold Preferred \$30/\$60/\$650</p> <p>HMO Gold Proactive</p> <p>HMO Gold Classic \$1,000 \$25/\$50/90%</p> <p>HMO Gold Classic \$2,000 \$40/\$80/100%</p> <p>HMO Silver Classic \$2,500 \$25/\$50/70%</p> <p>HMO Silver Secure \$3,500 \$40/\$80/\$600</p> <p>HMO Silver Classic \$4,250 \$40/\$80/100%</p> <p>HMO Silver Classic \$2,750 \$30/\$60/50%</p> <p>HMO Silver Proactive</p> <p>HMO Bronze Essential \$6,850 \$50/\$100/\$700</p> <p>DPOS Platinum Preferred \$10/\$20/\$100</p> <p>DPOS Platinum Preferred \$20/\$40/\$150</p> <p>DPOS Gold Preferred \$30/\$60/\$650</p> <p>DPOS Gold Classic \$1,000 \$25/\$50/90%</p> <p>DPOS Gold Classic \$2,000 \$40/\$80/100%</p> <p>DPOS Silver Classic \$2,500 \$25/\$50/70%</p> <p>DPOS Silver Secure \$3,500 \$40/\$80/\$600</p> <p>DPOS Silver Classic \$4,250 \$40/\$80/100%</p> <p>DPOS Silver Classic \$2,750 \$30/\$60/50%</p> <p>DPOS Bronze Essential \$6,850 \$50/\$100/\$700</p>	<p>Personal Choice PPO Plans:¹</p> <p>Platinum Preferred \$10/\$20/\$150</p> <p>Platinum Preferred \$20/\$40/\$150</p> <p>Gold Preferred \$35/\$70/\$600</p> <p>Gold Classic \$1,000 \$15/\$30/80%</p> <p>Gold Classic \$2,000 \$40/\$80/100%</p> <p>Silver Secure \$3,000 \$30/\$60/\$600</p> <p>Silver Classic \$3,300 \$40/\$80/100%</p> <p>Silver Classic \$2,500 \$30/\$60/80%</p> <p>Platinum HSA-50 \$1,600/100%</p> <p>Gold HSA-25 \$2,400/100%</p> <p>Gold HSA-0 \$1,900/100%</p> <p>Gold HSA-50 \$2,650/70%</p> <p>Silver HSA-0 \$3,200/100%</p> <p>Silver HSA-0 \$2,100/70%</p> <p>Silver HSA-0 \$2,700/90%</p> <p>Bronze HSA-0 \$5,200/50%</p> <p>Bronze HSA-0 \$6,550/100%</p> <p>Platinum HRA-50 \$1,850/100%</p> <p>Gold HRA-25 \$2,900/100%</p>	<p>Medicare Supplemental plan: MedigapSecurity</p> <p>Vision: _____</p> <hr/> <p>Dental plans:</p> <p>HMO & DPOS Adult DHMO Rider²</p> <p>PPO/HSA/HRA/HMO & DPOS Adult Preventive PPO Adult Preferred PPO Adult Premier PPO with Preventive Incentive</p>

*The Keystone Health Plan East HMO/DPOS Plans are underwritten by Keystone Health Plan East. PPO Plans are underwritten by QCC Insurance Company.

¹ Includes prescription drug, vision, and pediatric dental benefits.

² Available for HMO and DPOS plans only.



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SECTION B — Primary applicant information

Primary applicant name: Last, first, middle initial		Social Security Number (required)	
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: M 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)† Yes No	Primary dental office ID# (DHMO only)†		

† A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE to request a PCP or PDO directory (for HMO/DPOS plans only).

SECTION C — Family information (if applying)*

Spouse / domestic partner name: Last, first, middle initial		Social Security Number (required)		
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: M F	Relationship code:‡
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)† Yes No	Primary dental office ID# (DHMO only)†			

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: M F	Relationship code:‡
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)† Yes No	Primary dental office ID# (DHMO only)†			

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE to request a PCP or PDO directory (for HMO/DPOS plans only).

††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.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse	17 = Stepchild
02 = Child	20 = Subscriber / Self
09 = Adopted child	29 = Domestic Partner
10 = Foster child	31 = Court appointed guardian

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



SECTION C — Family information (continued)*

Dependent ^{††} name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: M F	Relationship code: [‡]
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) [†] Yes No	Primary dental office ID# (DHMO only) [†]			

Dependent ^{††} name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: M F	Relationship code: [‡]
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) [†] Yes No	Primary dental office ID# (DHMO only) [†]			

[†] A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE to request a PCP or PDO directory (for HMO/DPOS plans only).

^{††} 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.

[‡] Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
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17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

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

SECTION D — Personal information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact information

Home phone number ()	Business phone number ()	Best time to call: Morning Afternoon
Mobile phone number ()	Email address	Best location to call: Home Business Mobile

SECTION F — Household information

Do all applicants reside in the same household? Yes No	
If no, provide reason: _____ _____	
Applicant's name _____	Applicant's address _____
Applicant's name _____	Applicant's address _____

SECTION G — Other insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Shield plan?	Yes	No
B. Do you have any health insurance in effect?	Yes	No
C. Are you replacing the health insurance plan listed in A or B above?	Yes	No
If "Yes," termination date (mm/dd/yy): ____/____/____		

Important: Confirm group coverage prior to cancelling any existing coverage.

If you answered "Yes" to question A or B, provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION H - Additional information

1. Have you, your spouse / domestic partner, or any dependents used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use?	Yes	No
If "Yes,": Yes, but I am participating in a smoking cessation program. Yes, and I am not participating in a smoking cessation program.		
The above questions are applicable to members and their dependents age 21 and older.		
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____

SECTION I – Declarations and Conditions of Enrollment *Please read carefully before signing below.*

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 affiliate, 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 and select DPOS services, all medical or dental care must be initiated at the primary care office or primary 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 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.

SIGN HERE X _____ / /
Applicant/Parent or legal guardian signature Date (mm/dd/yy)

Group Administrator: Mail application to:

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

NOTE: Please make sure your Group Administrator has completed the gray-shaded section on page 2 of this application.

By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence Blue Cross and its subsidiaries (collectively "IBC") to send me information/data about IBC, including, but not limited to, information about my account and other insurance products and services. IBC may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to IBC is subject to IBC's Privacy Policy.



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Language Access Services

If you, or someone you're helping, has questions about Independence Blue Cross, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-275-2583 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independence Blue Cross, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-275-2583 TTY 711.

如對 Independence Blue Cross 有任何問題，請您或您所幫助的人联系我们提供的免費多語言信息服務。翻譯服務請撥打 1-800-275-2583。

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về Independence Blue Cross, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-800-275-2583.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы Independence Blue Cross, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-275-2583.

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Independence Blue Cross, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-275-2583 uffrufe.

Independence Blue Cross 와 관련하여 궁금한 사항이 있으신 경우, 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-800-275-2583 로 전화해 주십시오.

Se tu o qualcuno che stai aiutando avete domande su Independence Blue Cross, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-800-275-2583.

إذا كان لديك أو لدى شخص تساعد أسئلة بخصوص Independence Blue Cross، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-800-275-2583.

Si vous, ou quelqu'un que vous aidez, a des questions à propos d'Independence Blue Cross, vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-800-275-2583.

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über Independence Blue Cross haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-275-2583 an.

જો તમને અથવા તમે કોઈને મદદ કરી રહ્યા તેમાંથી કોઈને Independence Blue Cross વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-800-275-2583 પર કોલ કરો

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu Independence Blue Cross, mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-800-275-2583.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan Independence Blue Cross, ou gen dwa pou resewva èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-275-2583.

បើអ្នក ឬក៏នរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Independence Blue Cross អ្នកមានសិទ្ធិក្នុងការទទួលជំនួយនិង ព័ត៌មានជាភាសារបស់អ្នក ដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅទូរសព្ទទៅលេខ 1-800-275-2583 ។

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Independence Blue Cross, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-275-2583.

Díí kwe'é atah nilínígíí Independence Blue Cross haada yit'éego bína ídílkidgo éi doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídílkidgo bee ná ahóót'i'díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'í' hodíílnih 1-800-275-2583.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa Independence Blue Cross, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-800-275-2583.

ご本人やお客様の周りの人が、Independence Blue Cross についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用の方は、1-800-275-2583 までお電話ください。

اگر شما یا شخصی که به وی کمک می کنید، در رابطه با Independence Blue Cross سوالی دارید، این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-800-275-2583 تماس حاصل فرمایید.

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

Independence Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Blue Cross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters; and 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, and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have five ways to file a grievance directly with Independence Blue Cross: in person or by mail: Independence Blue Cross, ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103; by phone: 888-377-3933 (TTY 711), by fax: 215-761-0245, or by email: civilrightscoordinator@ibx.com. If you need help filing a grievance, our 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, DC 20201, 1-800-368-1019, 800- 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Effective Date: July 18, 2016, Version 1.0