Capital BlueCross
Independent Licensee of the BlueCross BlueShield Association

Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company
Independent Licensees of the BlueCross BlueShield Association

APPLICATION FOR NEW GROUPS ENROLLING 2–50 SUBSCRIBERS

Dependable Health Care Coverage from the Capital BlueCross Family of Companies

GROUP ADMINISTRATOR – You must complete all areas in the Group Administrator Box before submitting this application to Capital BlueCross.

GROUP INFORMATION (For Group Administrator Use) – Print the Employer's Name, Group Name (if different from employer's name), and Group Number/Subgroup Number assigned by Capital BlueCross. Complete the Class of the Subscriber. Indicate if the waiting period has been met. For Association Groups, print the Employer's Address, the Member Firm ID, and the Member Firm ID Effective Date. For all groups, print the Effective Date of Coverage and Date Hired. Indicate if employer employs (1) 20 or more employees, or (2) 100 or more employees, within the definition of the Medicare Secondary Payer (MSP) Laws.

MEDICARE SECONDARY PAYER INSTRUCTIONS (For Group Administrators) – An employer employs "*20 or more employees*" if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. 42 C.F.R. § 411.170(a)(2)(i); Medicare Secondary Payer Manual. An employer employs "*100 or more employees*" if the employer employed at least 100 employees on 50 percent or more of its regular business days during the previous calendar year. 42 C.F.R. § 411.101 (Large Group Health Plan Definition); Medicare Secondary Payer Manual. Special rules apply with respect to multi-employer group health plans. Please note that it is the **Group's responsibility** to assure that members are enrolled correctly consistent with the Medicare Secondary Payer Laws. The MSP provisions and regulations can be found at 42 U.S.C. §1395y(b) and 42 C.F.R. Part 411 and can be found in your local law library. You can also find information at **www.cms.hhs.gov/home/medicare.asp**.

REASON CODES (For Group Administrator Use) – Place a check mark in the appropriate box to indicate the reason for completing the application–Open Enrollment or Initial Eligibility. Enter the appropriate code and date for the enrollment. Refer to the back of the application for appropriate codes and descriptions.

INSTRUCTIONS TO SUBSCRIBER

IMPORTANT: Print clearly and complete this form accurately to help us process your enrollment information as quickly as possible. If you have any questions about completing the Enrollment Form, see your Group Administrator or call Customer Service at **1-800-962-2242** (Capital BlueCross) or **1-800-669-7061** (Keystone Health Plan Central).

Please send the completed application to:

Account Administration
Capital BlueCross
PO Box 772612
Harrisburg, PA 17177-2612

NF-225 (9/2012)

Account Administration
Capital BlueCross
PO Box 772612
Harrisburg, PA 17177-2612

INSTRUCTION SHEET

Capital BlueCross – 1-800-962-2242
Keystone Health Plan® Central – 1-800-669-7061
www.capbluecross.com

1. **SUBSCRIBER INFORMATION** – If you do not have an identification number, print your Social Security Number as the Subscriber Identification. Print your Birth Date. Check the appropriate boxes indicating your sex and marital status. Print your Name (Last, First, Middle Initial), current Mailing Address, and provide your Home Email Address and Home/Cell and Work Phone Numbers, including Extension (required in the event Capital BlueCross needs to notify the enrollee of benefit information). Check the appropriate box for Employment Status and print the Average Number of Hours Worked Per Week. If Retired, enter the retirement start Date. If your Employment Status is not one of the choices listed, please complete the Other (Explain) field.
2. **ENROLLMENT INFORMATION** – Print the Name (First, Middle Initial, and Last Name if different from the subscriber) of all your dependents who are eligible for health care coverage and who are to be enrolled under your contract. Check the appropriate box to indicate sex of spouse and each dependent's relationship to you. (If the dependent is other than a son or daughter, write the relationship in the space titled "OTHER").

   Print the Social Security Number and the full Birth Date of each dependent. If the spouse or dependent's address is different from the Subscriber's due to a Qualified Medical Child Support Order (QMCSO), a copy of the court order is required (along with the alternate address) to process the address change. Provide this information to your Group Administrator to submit with this application. If the address is different due to Act 150 (The Spousal and Child Medical Support Act 150 of PA), contact Customer Service (the numbers are listed on this application) so the appropriate forms may be mailed to you. Be sure to have the form notarized before returning it to us.
3. **COVERAGE SELECTION** – Select the coverage for which you (and/or your dependents) are applying. When multiple benefit levels are offered (i.e., "high," "low," "1," "2"), indicate the benefit level chosen in the column. Otherwise, place an "A," to add, in the column. If you are unsure which types of coverage you may add, contact your Group Administrator.

   Note: For subscribers enrolling in *HMO* coverage, the service area limitations are listed on the back of the form. If you are eligible for Medicare coverage and intend to apply for enrollment in one of our Medicare plan options, please call 1-800-976-2242.
4. **PHYSICIAN OF CHOICE** – Physician of Choice selection requirements vary by product. The following products involve Physician of Choice selection:
   - With PPO *Plus* coverage, selection of a Physician of Choice is *voluntary,* and specialty care from participating providers may be accessed directly, without a Physician of Choice referral.
   - With *POS* coverage, selection of a Physician of Choice is required, and in order to obtain the highest level of benefits, the selected Physician of Choice must provide referrals for nonemergency, specialty, and other care.
   - With *HMO* coverage, selection of a Physician of Choice is required, and the selected Physician of Choice must provide referrals for nonemergency, specialty and other care. Print your Physician of Choice group practice name and group Physician of Choice Code number (found in your Capital BlueCross Provider Directory or Keystone Health Plan Central Provider Directory or on our website—www.capbluecross.com). You and each member of your family can select his or her own Physician of Choice from the Directories or website listing. The Directory or website may indicate that the physician you wish to select is available to current patients only. If you are currently a patient of that physician, please indicate that in this section on the enrollment form. If you are not currently a patient, please select a different Physician of Choice.
5. **MEDICARE INFORMATION** – Complete this section only if you or your dependents are eligible for Medicare benefits. Print the Medicare Claim Number and Effective Date(s) found on your red, white, and blue Medicare Health Insurance Card. Check the box in the appropriate column under the "Reason/Effective Date for Medicare Coverage" – whether eligible for Medicare by Age; by Disability under Medicare; or by End Stage Renal Disease (ESRD). If you or your dependents are eligible due to multiple reasons, please enter the Effective Date for each reason in the applicable date field.
6. **HANDICAPPED DEPENDENTS** – List the Names of any Handicapped Dependents enrolled under your contract. If this section is completed, additional information may be sent to you.
7. **OTHER INSURANCE COVERAGE** – Complete this section if you and/or any of your dependents currently have health care coverage with another insurance company. Print the Name of each person holding the contract, the Name of the Health Care Plan or Insurance Company, and the Identification or Policy Number. If this section is completed, additional information may be sent to you.
8. **STUDENT INFORMATION** – Complete this section if any of your dependents are a full-time student at an accredited School or College/University. Print the Name of the dependent(s), the Name of the School or College/University, and the anticipated Graduation Date(s).
9. **STATEMENT OF APPLICATION – Read this section carefully. You must sign and date the application for it to be processed. Capital BlueCross will not accept your application if this section is not completed.**
10. **DISCLOSURE AUTHORIZATION FORM** – Before completing the Disclosure Authorization Form, remove the tissue paper, sign and date the appropriate fields, and retain a copy for your records. Please remember we must have a signature for every family member choosing to enroll—including your spouse and every dependent. If the dependent is 18 or older, the dependent's signature is required. If the dependent is under age 18, a parental signature is required. A qualified "personal representative" under HIPAA may sign on behalf of a member.

Tear off this page and use it to help you complete this form. Then discard.

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APPLICATION TO ENROLL
NEW GROUPS 2-50 SUBSCRIBERS
(Please print or type)

Keystone HEALTH PLAN CENTRAL
A Capital BlueCross Company
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1-800-962-2242 **www.capbluecross.com** **1-800-669-7061**

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing all sections of this form.

GROUP ADMINISTRATOR: You must complete all areas in the box below before submitting this application to Capital BlueCross.

Employer's Name	
Group Name *(if different from above)*	
Group Number / Subgroup Number / Class	
Does Employer employ 20 or more employees under the MSP laws? ☐ Yes ☐ No	
Does Employer employ 100 or more employees under the MSP laws? ☐ Yes ☐ No	
Employer's Address *(for Association Groups Only)*	Member Firm ID Eff Date of Above
Effective Date of Coverage: Date Hired	Has waiting period been met? ☐ Yes ☐ No

REASON CODES *(See back for codes and descriptions)*

☐ Open Enrollment

☐ Initial Eligibility CODE

☐ Other (Please Explain)

1. SUBSCRIBER INFORMATION

Subscriber Identification	Birth Date	☐ Male ☐ Female
Subscriber Name (Last, First, M.I.)		☐ Single ☐ Married
Mailing Address (Include street address, city, state and ZIP Code)	New Address? ☐ Yes ☐ No County	
Home Phone Number / Cell Phone Number / Work Phone Number / Ext.	Home Email Address	

Employment Status
☐ Active (Full-Time) ☐ Retired—(Date) _____ ☐ Hourly ☐ Exempt ☐ Union
☐ Active (Part-Time) ☐ Other—(Explain) _____ ☐ Salary ☐ Non-Exempt ☐ Non-Union

Average Number of Hours Worked Per Week

2. ENROLLMENT INFORMATION

3. COVERAGE SELECTION

4. PHYSICIAN OF CHOICE

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date		Trad.	Comp.	PPO	PPO Plus	POS	HMO	Senior	Drug	Dental	Vision	Physician of Choice selection required for *POS* and *HMO*, optional for PPO *Plus*.
SUBSCRIBER			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Other			☐ ADD											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
If you need an alternate address for a spouse or dependent, please see No. 2 on the INSTRUCTION SHEET.														Indicate Practice Names & Codes (Refer to Applicable Provider Directory)

5. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Please list the starting date for each reason in the applicable date field. *(Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)*

Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s)		Reason/Effective Date for Medicare coverage		
		Hospital (Part A)	Medical (Part B)	☐ Age	☐ Disabled	☐ ESRD
				Effective Date:	Effective Date:	Effective Date:
				Effective Date:	Effective Date:	Effective Date:

6. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. *(Please attach a separate sheet of paper if additional space is needed)*

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

8. STUDENT INFORMATION

Complete the following information for DEPENDENTS who are enrolled as a full-time student at an accredited School or College/University. *(Please attach a separate sheet of paper if additional space is needed)*

Student's Name	Name of School or College/University	Expected Graduation Date

9. STATEMENT OF APPLICATION

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature _____ Date _____

White - Capital BlueCross Copy Yellow - Group Administrator Copy Pink - Subscriber Copy

Use this application for initial enrollment of new groups enrolling 2-50 subscribers and the instances listed below:

INITIAL ELIGIBILITY:

Code	Definition
A :	New group enrollment.
B :	Newly hired – The applicant can be enrolled at the time of hire or after a waiting period established by the group.
C :	The subscriber or dependent elects COBRA coverage. (Indicate if employee or dependent.)
D :	The Association acquires a new employer group.
E :	Union member now eligible for coverage.

For enrollment changes (i.e., address change, removing dependents, or terminating coverage) complete the *Application to Enroll or Change Enrollment* Form (NF-2).

OTHER/EXPLANATION:

If the reason for the enrollment is other than listed above, please explain on the front of the application.

STATEMENT OF APPLICATION

I hereby apply for the coverage indicated. I understand this application is subject to approval by Capital BlueCross, its subsidiaries, and/or reinsurers, and any coverage provided will be subject to the terms of the agreements and/or contracts issued to me. **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.** I verify that the information supplied by me is correct to the best of my knowledge, information, and belief.

For those applicants residing outside Keystone Health Plan® Central's (KHP Central) Service Area:
I have been offered the option of enrolling in KHP Central's Health Maintenance Organization. I understand that if my place of residence is not within KHP Central's Service Area, the majority of the care that I and my dependents receive as KHP Central members must be provided or referred by a KHP Central Physician of Choice, according to the terms of the KHP Central Certificate of Coverage. I have reviewed KHP Central's listing of primary care practices and have selected one which is sufficiently convenient to provide such care. I understand the conditions of enrollment and wish to enroll in KHP Central. KHP Central's Service Area includes the following counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

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Capital BlueCross
PO Box 773131
Harrisburg, PA 17177-3131

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DISCLOSURE AUTHORIZATION FORM

Please be sure to remove the tissue paper before completing this form.

By signing this form, I authorize Capital BlueCross to collect and process my individually identifiable health information described below so that Capital BlueCross has the information it needs to determine the premium to be charged to my employer, and to conduct clinical management activities if I enroll in Capital BlueCross coverage.

By signing this form, I also authorize the insurers and health plans that have covered me in the past, and pharmacy benefit managers and reinsurers that have performed services for the insurers and health plans that have covered me in the past, to disclose claims records and other health information. Such information may include information protected by state law including, but not limited to, HIV, mental health, and substance abuse.

I understand the nature of this release and I understand that I can refuse to sign this authorization. Capital BlueCross will not refuse to enroll me or deny me benefits if I refuse to sign this form. This form does not apply to and I do not authorize disclosure of psychotherapy notes. I understand that, with respect to any of the parties described above, I may revoke this authorization at any time. To revoke the authorization for any of the parties named above, I understand that I must give written notice to that party, and that to revoke the authorization for all parties, I must give written notice to each of my former insurers, health plans, pharmacy benefit managers, and reinsurers, in addition to Capital BlueCross. My revocation will not affect the rights of anyone who has acted in reliance on the authorization prior to receiving notice of my revocation. Unless revoked earlier, this authorization will be valid until the initial underwriting determination is made by Capital BlueCross. I understand that the information covered by this form, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

GROUP INFORMATION

Group Name:	Group ID Number:

AUTHORIZATION SIGNATURES

Print Name of Proposed Insured	Signature of Proposed Insured (Subscriber or Subscriber's Personal Representative†)	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Spouse or Spouse's Personal Representative†)	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date

† An individual's personal representative includes an individual's legal guardian, or someone who has power of attorney over the individual's health care decisions. A copy of the power of attorney or other court initiated documents should be included along with this form, if applicable.

* If the dependent is 18 or older, the dependent's signature is required. If the dependent is under age 18, a parental signature is required. A qualified "personal representative" under HIPAA may sign on behalf of a member.