HIGHMARK® HEALTH INSURANCE COMPANY

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

❑ ENROLLING
❑ WAIVING

I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No.

Address | Email Address

City | State | Zip | Home Phone | Work Phone

Marital Status (Please check one):
❑ Single/Widowed
❑ Married
❑ Divorced

Employment Status
❑ Active ❑ COBRA ❑ Disabled

Date of Full-Time Hire
Mo Day Yr

Hours Worked Per Week

❑ COBRA
Start Date _____
End Date _____

COBRA REASON:
❑ Deceased ❑ Involuntary Lay-Off Date of Event _____
❑ Left Employment ❑ Other _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

Covered Dependents and Relationship	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Sex	Height	Weight	Dependent Status If Over Age 26	Med	Vis	Den
Self			/ /	❑ M ❑ F						
❑ Spouse ❑ Dom. Part.*			/ /	❑ M ❑ F						
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship: ❑ Other: _____

III WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s)) EMPLOYEE AND EMPLOYER MUST SIGN BELOW

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

REASON FOR DECLINING MEDICAL COVERAGE:
❑ Insured under spouse's contract with the following insurance carrier:
_____
❑ Other: _____

VISION

I HEREBY DECLINE VISION COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
_____

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 qualifying event occurs before coverage will be offered.

Employee Signature | Date | Employer Signature | Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

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 plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, 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.

BOTH EMPLOYEE AND EMPLOYER SIGNATURES ARE REQUIRED FOR WAIVERS

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

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder

Policy Holder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status
			❑ Active ❑ Retired - List Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: EMPLOYEE AND EMPLOYER MUST SIGN BELOW

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

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.

Authorized Employer Signature _____ Date _____

Print Company Name _____

Employee Signature _____ Date _____

Print Employee's Name _____

HIGHMARK® HEALTH INSURANCE COMPANY

For New Business:
Highmark
Attn: Producer Affairs (SP 6E)
P.O. Box 890089
Camp Hill, PA 17089-0089

VI MEDICAL HISTORY INFORMATION

Please answer each question below as completely as possible. NOTE: Medical information disclosed in this section will not be used to determine the eligibility of you and/or your dependents to enroll in the coverage requested. **If you or any of your dependents have any of the conditions listed below, please check all numbers and circle the specific condition(s) that apply.**

Then, in the **Explanation** section below, please give details for all diagnosis circled in questions 1 -27. Attach additional sheets if necessary.

- ❑ 1. Cancer, Leukemia, Tumor or Cyst
- ❑ 2. Heart Surgery (Angioplasty, Stent or Bypass), Heart Disease, Implanted Pace Maker or Defibrillator, Irregular Heartbeat, Heart Murmur, Heart Regurgitation, Chest Pain, Congestive Heart Failure or Mitral Valve Prolapse
- ❑ 3. Vasculitis or Peripheral Vascular Disease
- ❑ 4. High Blood Pressure, and/or High Cholesterol
- ❑ 5. Emphysema, COPD, Cystic Fibrosis, Asthma or Allergies
- ❑ 6. Sleep Apnea, or Disease of the Throat, Ears, Nose, Sinuses or Eyes (except glasses)
- ❑ 7. Ulcerative Colitis, Crohn's, Diverticulitis, Stomach Ulcers, Acid Reflux, GERD, Hernia, Gallbladder or Rectal Disorders
- ❑ 8. Diabetes Type I or II
- ❑ 9. Hypothyroid, Hyperthyroid, Goiter, Pituitary, Pancreas or Glandular Disorders or Disorders requiring Growth Hormones
- ❑ 10. Hepatitis (please circle type): A, B, C, or Autoimmune Hepatitis
- ❑ 11. Bladder, Kidney, Prostate, Testicular, Uterine, Kidney Failure or Dialysis, Abnormal PAP in the last 5 years or Breast Condition
- ❑ 12. Any female to be covered currently Pregnant? Due Date _____. If yes, how many fetuses (single, twins, triplets, etc.). If pregnant, please give details including any complications
- ❑ 13. Arthritis (Osteo, Rheumatoid or Other), Joint Replacement, Joint Pain, Lupus, Fibromyalgia, Fractures or Limb Loss
- ❑ 14. Neck or Back Pain, Disorders of the Spine or Disc Herniation/Bulging
- ❑ 15. Head or Spinal Injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis
- ❑ 16. Any blood disorder such as Anemia or Hemophilia
- ❑ 17. Aneurysm (Aortic or Cerebral), Blood Clot, TIA or Stroke
- ❑ 18. AIDS, HIV, Chronic Fatigue Syndrome, any Immune Suppressed Illness
- ❑ 19. Depression, Anxiety, ADD, ADHD, Psychotic Disorder
- ❑ 20. Any Drug or Alcohol Problems
- ❑ 21. Any Stem Cell or Organ Transplant (planned, recommended or already performed)
- ❑ 22. Cigarette or Tobacco use?
- ❑ 23. Any hospitalizations in the last 5 years (Please give full details below)
- ❑ 24. Any future surgeries discussed, planned or recommended (Please give full details below)
- ❑ 25. Currently taking any prescription medications? Please give details below to include the name of the medication and condition for which the medication is needed.
- ❑ 26. Are there any other medical conditions not listed above? (Please give full details below)
- ❑ 27. In the last five years have you been treated (including medication) for, diagnosed with, or sought treatment from a member of the medical profession for : Macular Degeneration, Retinitis Pigmentosa, Retinopathy? ❑ Yes ❑ No

VII EXPLANATION SECTION

Provide an explanation for each box marked in questions 1 - 27. Any prescription medications that are **not** in response to the questions above - please list prescription medication and the reason for the medication. If additional space is needed, please attach additional sheets. When completing the application, please 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 that you or your dependent(s) may be at risk.

Question number	Patient Name	Diagnosis	Date Diagnosed	Type of Treatment	Medications	Date of most recent inpatient stay		Is ongoing treatment required?	If yes, please explain
						From	To		

VIII IMPORTANT: EMPLOYEE/APPLICANT SIGNATURE (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office. I further acknowledge and agree that Highmark may disclose enrollment, disenrollment summary health and/or premium billing information requested by the POR (Producer of Record) for purposes of inputting, updating and/or reviewing the same for the above identified business.

To the best of my knowledge and belief, the information provided on this application is true and correct.

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.

Employee Signature: **Print Employee Name:** **Date:**