Independence Blue Cross

Universal Enrollment Form

1 Subscriber or Member Enrollment or Change – Employee MUST Complete in Full

New
- ☐ Open Enrollment
- ☐ Life Event
- ☐ New Hire
- ☐ KHPE Non-Group

Change
- ☐ Address
- ☐ Rehire
- ☐ Last Name
- ☐ Dental Office
- ☐ Primary Care Office

Life Event Change
- ☐ Marriage
- ☐ Other
- ☐ Add a Dependent
- ☐ Delete a Dependent

Life Event Date _____

Other Change
- ☐ COBRA

Effective Date _____

Effective Date of Coverage

Terminate Contract
- ☐ Terminated Employment
- ☐ Full Time to Part Time
- ☐ Deceased. Indicate date.
- ☐ Other. Please explain. _____

2A Plan (please specify co-pay or benefit option):

PPO | HMO | POS | RX | Vision | Dental

- ☐ CMM
- ☐ Traditional
- ☐ Security 65

Employment Status
- ☐ Active
- ☐ Retiree

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 | First Name | M.I. | Gender M/F | Date of Birth

Street Address | Apartment or Suite | City | State | ZIP Code

Telephone Number including Area Code
- Home
- Work

Coverage Information
- ☐ Employee Only
- ☐ Employee and Child
- ☐ Employee and Spouse
- ☐ Employee and Children
- ☐ Family

Date of Hire

Primary Care Office Number

Primary Care Office Name _____ Check if current patient. ☐

Primary Dental Office Number

Primary Dental Office Name _____ Check if current patient. ☐

4 Dependent Information – Please provide all information for each person to be covered. Please attach additional sheets if required.

Name	Social Security Number	Primary Care Office Number	Primary Care Office Name	Check if current patient.	M.I.	Gender	Date of Birth	Primary Dental Office Number	Check if current patient.	Will other health insurance be in effect? If yes, see 5.	Dependent over 19?
Spouse Last Name / First Name				☐					☐	Yes ☐ No ☐	Provide verification.
Child Last Name / First Name				☐					☐	Yes ☐ No ☐	Student ☐ Disabled ☐
Child Last Name / First Name				☐					☐	Yes ☐ No ☐	Student ☐ Disabled ☐
Child Last Name / First Name				☐					☐	Yes ☐ No ☐	Student ☐ Disabled ☐

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4A Dependent Information -- If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? Yes ☐ No ☐

Is any dependent's last name different from yours? Yes ☐ No ☐

If you answered yes to either question, please explain.

5 Other Insurance Information

5A 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

5B Are you or any of your dependents currently receiving Medicare Benefits? Yes ☐ No ☐ If yes, please give details.

	Name	Medicare Number	Part A Effective Date	Part B Effective Date
Self				
Spouse				
Child				
Child				

Reason

Check all that apply.

Age ☐

Disability ☐

ESRD ☐

6 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/Work Location

Account Number

Employer or Group Administrator Signature

Date _____

7 Signature and Verification

Please read carefully and sign 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 and CMM 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 institution 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 administrating 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 POS 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 providing services to furnish Keystone, its affiliates and ancillary service providers who are responsible for administrating 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 choose a Point of Service Product, 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 plan coverage only at the time my employer and Keystone specify. Keystone POS program Self-Referred benefits may be underwritten by QCC Insurance Company. Referred benefits underwritten or administered by Keystone Health Plan East and QCC Insurance Company and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.

Employee Signature

Date _____

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Subscriber's County of Residence