Capital BLUE

Customer Service
800.962.2242 • capbluecross.com

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

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): Please print the Group/Employer information in the applicable boxes, including the Class ID, Effective Date, and Hire Data. Check the appropriate box to indicate the action to be taken (Enrollment, Change, or Terminate — see Reason Codes for reference). Please include the appropriate Plan ID for each product (medical, dental, vision, etc.) the employee has selected.

REASON CODES (For Group Administrator Use): Place a check mark in the appropriate box to indicate the reason for completing the application. (If multiple changes occur, use the code most applicable.) Refer to page 2 of the application for appropriate codes and descriptions.

Please send the completed application to:

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

INSTRUCTIONS TO SUBSCRIBER

1. **SUBSCRIBER INFORMATION:** Enter the appropriate information in the applicable fields. Check the box to indicate reason(s) for submitting this Enrollment/Change request. In the Subscriber ID/SSN box enter your subscriber identification number as it appears on your ID card if you are a current subscriber, or if a new subscriber, enter your social security number (SSN). Enter your name (first, last), birth date, current mailing address, email address, and phone number. Check the appropriate box for employment status. If retired, enter the retirement start date. Check the disabled box "Yes" if you qualify for Medicare and also complete Section 4 of this application. In the PCP (Primary Care Physician)/ NPI (National Provider Identifier) number box, enter your group physician of choice code number. This field is required if you are enrolling in an HMO or Gatekeeper PPO (GPPO) product. Your PCP/NPI number can be found in the Capital BlueCross Provider Directory, Keystone Health Plan® Central Provider Directory, or on our website — capbluecross.com. Please indicate whether you are a current patient of this provider. You and each member of your family can independently select a physician of choice from the directories or website listing.
2. **PLAN OPTIONS:** Check all appropriate plan boxes.
3. **ENROLLMENT/CHANGE INFORMATION:** For each of your spouse/dependent(s) check the box indicating the reason(s) for submitting this form and enter their name, social security number, relationship, and birth date. If the dependent is other than a son or daughter (i.e. legal dependent), complete Section 3e. Check the disabled box "Yes" for any disabled dependents enrolled under your contract. If your disabled dependent(s) also qualify for Medicare, please complete Section 4 of this application. Enter your dependent's physician of choice group code number in the PCP/NPI number box. This field is required if you are enrolling in an HMO or GPPO product. Complete the student box for any dependent that is a full-time student at an accredited school or college/university. Select the coverage for which spouse or dependent(s) are applying or changing coverage.

   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 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 number is listed on this application) so the appropriate forms may be mailed to you. Be sure to have the form notarized before returning it.
4. **MEDICARE COVERAGE INFORMATION:** Complete this section only if you or your dependent(s) are eligible for Medicare benefits. Enter the Medicare 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, disability, 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.
5. **CHANGE INFORMATION:** Complete this section to make a change in name, social security number, or birth date. Check the appropriate box to indicate who the change is for.
6. **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.**

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

INITIAL ELIGIBILITY:

Code Definition

- A: New group enrollment and/or group medical only benefit change.
- 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: Union member now eligible for coverage.

LIFE STATUS CHANGES (If multiple changes occur, use the code most applicable):

Code Definition

- E: The subscriber marries.
- F: The subscriber has a child, adopts, acquires a stepchild, or becomes legal guardian of a child.
- G: The subscriber divorces or legally separates and no longer has coverage through a spouse.
- H: The subscriber has a change in employment status (i.e., from part-time to full-time, hourly to salary, union to non-union).
- I: The subscriber has a change in his/her Medicare Primary Status (e.g., the employee retires and Medicare becomes primary).
- J: The subscriber and/or dependent loses coverage under another benefit plan.
- K: The subscriber is reinstating terminated coverage (for instance, from a leave of absence, layoff, etc.).

SUBSCRIBER TERMINATIONS (Including all dependents):

Code Definition

- IS01: The subscriber is no longer employed/requests cancel.
- IS02: The subscriber is deceased.
- IS03: The contract cancel reason is unknown.
- IS05: The subscriber has coverage with another Blue plan.
- IS06: The subscriber selected coverage through another insurance company.

DEPENDENT TERMINATIONS:

Code Definition

- IM01: The dependent is deceased.
- IM03: The dependent has coverage with another Blue plan.
- IM04: The dependent has coverage through another insurance company.
- IM05: The dependent marries.
- IM06: The dependent is over the age limit.
- IM13: The dependent is divorced.

OTHER/EXPLANATION:

If the reason for the enrollment/change is other than listed above, please explain on 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.

Rescissions Disclaimer for Statement of Attestation of Termination of Coverage: By submitting member termination of health care coverage, the group hereby represents and warrants that the terminations comply with the Patient Protection and Affordable Care Act. Contributions of any funds for health care coverage will not be obtained from the member for any period beyond the date of termination. The contract holder is solely responsible for the termination of the member's health care coverage.

For those choosing CareConnect: I have been offered the option of enrolling in CareConnect, a gatekeeper PPO. This means I must select a primary care physician and abide by referral processes for specialists to receive the highest level of coverage. I have reviewed the list of primary care practices that participate in the CareConnect gatekeeper PPO and have selected one that is sufficiently convenient to provide such care. CareConnect is available in the following counties: Cumberland, Dauphin, and Perry.

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 that 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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APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

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

Group Name	Group Number	Subgroup Number	Class	Effective Date of Coverage/Change	Date Hired
				____ / ____ / ______	____ / ____ / ______

REASON CODES *(see page 2 for codes and descriptions)*

Enrollment	Change of Enrollment	Termination
❑ Open Enrollment ❑ Initial Eligibility Change: CODE ________ ❑ Other *(please explain)*: ____________	❑ Life Status Change: CODE ________	❑ Termination: CODE ________
Date of Change ____ / ____ / ______	Date of Change ____ / ____ / ______	Date of Termination ____ / ____ / ______

Medical Plan ID	Rx Plan ID	Dental Plan ID	Vision Plan ID

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 6 of this form. Subscriber information must be completed for any transaction.

1. SUBSCRIBER INFORMATION *(please print clearly)*

❑ Add ❑ Change ❑ Remove	Subscriber's First Name	Subscriber's Last Name	❑ Male ❑ Female	Subscriber's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______

Street Address	City	State	ZIP Code	New Address ❑ Yes ❑ No	County	Phone Number ❑ Home ❑ Cell ❑ Work ( ) ____ – ______	Email Address

Employment Status	❑ Active Full-Time ❑ Active Part-Time	❑ Retired *(date)* ____ / ____ / ______ ❑ Other *(explain)* ______	❑ Exempt ❑ Non-Exempt	❑ Union ❑ Non-Union	Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No

2. PLAN OPTIONS

❑ PPO ❑ PPO Plus ❑ PPO Choice ❑ CareConnect℠ GPPO ❑ HMO ❑ Senior ❑ Rx ❑ Traditional ❑ FSA ❑ HSA ❑ HRA ❑ Dental ❑ Vision

3. ENROLLMENT/CHANGE INFORMATION

a. Spouse

❑ Add ❑ Change ❑ Remove	Spouse's First Name	Spouse's Last Name	❑ Male ❑ Female	Spouse's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______
Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No	❑ Medical ❑ Dental ❑ Vision ❑ Rx		

b. Dependent

❑ Add ❑ Change ❑ Remove	Dependent's First Name	Dependent's Last Name	❑ Son ❑ Daughter	Dependent's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______
Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No	❑ Medical ❑ Dental ❑ Vision ❑ Rx	Student: ❑ Yes ❑ No Graduation Date: ____ / ____ / ______ Name of School: ____________	

c. Dependent

❑ Add ❑ Change ❑ Remove	Dependent's First Name	Dependent's Last Name	❑ Son ❑ Daughter	Dependent's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______
Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No	❑ Medical ❑ Dental ❑ Vision ❑ Rx	Student: ❑ Yes ❑ No Graduation Date: ____ / ____ / ______ Name of School: ____________	

Subscriber ID: ____________

3. ENROLLMENT/CHANGE INFORMATION (continued)

d. Dependent

❑ Add ❑ Change ❑ Remove	Dependent's First Name	Dependent's Last Name	❑ Son ❑ Daughter	Dependent's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______
Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No	❑ Medical ❑ Dental ❑ Vision ❑ Rx	Student: ❑ Yes ❑ No Graduation Date: ____ / ____ / ______ Name of School: ____________	

e. Other *(see section #3 of the instructions for further guidance)*

❑ Add ❑ Change ❑ Remove	Other's First Name	Other's Last Name	❑ Male ❑ Female	Other's ID/SSN __ __ __ __ __ __ __ __ __	Birth Date *(MM/DD/YYYY)* ____ / ____ / ______
Disabled? ❑ Yes ❑ No	PCP/NPI Number	Current Patient? ❑ Yes ❑ No	❑ Medical ❑ Dental ❑ Vision ❑ Rx	Student: ❑ Yes ❑ No Graduation Date: ____ / ____ / ______ Name of School: ____________	

If you have more dependents, please attach an additional application.

4. 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 Health Insurance Card for the Medicare number and effective dates.)*

Subscriber or Dependent First Name	Subscriber or Dependent Last Name	Medicare Number
Effective Date(s) Hospital (Part A) ____ / ____ / ______ Medical (Part B) ____ / ____ / ______	Reason/Effective Date for Medicare Coverage ❑ Age ____ / ____ / ______ ❑ Disabled ____ / ____ / ______ ❑ ESRD ____ / ____ / ______	
Subscriber or Dependent First Name	Subscriber or Dependent Last Name	Medicare Number
Effective Date(s) Hospital (Part A) ____ / ____ / ______ Medical (Part B) ____ / ____ / ______	Reason/Effective Date for Medicare Coverage ❑ Age ____ / ____ / ______ ❑ Disabled ____ / ____ / ______ ❑ ESRD ____ / ____ / ______	

5. CHANGE THE FOLLOWING INFORMATION

Change is for ❑ Subscriber ❑ Dependent

Name	From: *(First):* ____________ *(Last):* ____________	To: *(First):* ____________ *(Last):* ____________
Birth Date	From: ____ / ____ / ______	To: ____ / ____ / ______
Social Security Number	From: __ __ __ __ __ __ __ __ __	To: __ __ __ __ __ __ __ __ __

6. STATEMENT OF APPLICATION

Note: An authorized Group Administrator may sign for subscriber terminations (including all dependents).

By signing this application, I am indicating that I have read the STATEMENT OF APPLICATION. I verify that the information given is true and correct.

By providing a telephone number and/or an email address, I hereby authorize Capital BlueCross, its affiliates, subsidiaries and/or agents (collectively "Capital BlueCross") to communicate with me by phone, text messages, faxes, and/or emails for billing, transactional, informational, marketing, or any other purposes including, without limitation, calls or messages made or sent using an automatic telephone dialing system or artificial/prerecorded voice. I understand my consent is not a condition of purchasing any goods or services and that I may opt out at any time.

Subscriber's Signature	Date ____ / ____ / ______