



Capital BlueCross



Keystone
HEALTH PLAN® CENTRAL
A Capital BlueCross Company

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

*Dependable Health Care Coverage from the
Capital BlueCross Family of Companies*

The Group Administrator must complete all shaded sections before an application is submitted 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. 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/Change and Date Hired. Indicate if your company employs 20 or more employees. Complete the Class of the Subscriber.

TYPE OF ACTIVITY (For Group Administrator Use) – Check the appropriate box to indicate whether the subscriber is enrolling in, changing, or terminating group coverage.

REASON CODES (For Group Administrator Use) – Place a check mark in the appropriate box to indicate the reason for completing the application. If the reason is due to an initial eligibility, life status change, or termination of a subscriber or subscriber's dependent, enter the appropriate code and date the change occurred. (If multiple changes occur, use the code most applicable.) Refer to the back of the application for appropriate codes and descriptions.

Please send the completed application to:

Capital BlueCross
Account Administration
PO Box 772616
Harrisburg, PA 17177-2616

INSTRUCTION SHEET

INSTRUCTIONS TO SUBSCRIBER

IMPORTANT: Print Clearly and complete this form accurately to help us process your enrollment or change information as quickly as possible. If you have any questions about completing the Enrollment/Change 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).

- 1. SUBSCRIBER INFORMATION** – If you are a current subscriber, clearly print your identification number as it appears on your ID card. If you are a new subscriber and 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 Email Address and Home and Work Phone Numbers, including Extension. Check the appropriate box for Employment Status and print the Average Number of Hours Worked Per Week. When making only an address change, print your Subscriber Identification/Social Security Number, Name (Last, First, Middle Initial), new Mailing Address, and check the “Yes” block for “New Address.” Provide your Home Phone Number and complete section 10.
- 2. ENROLLMENT/CHANGE 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. Be sure to indicate whether the dependent is being “added” or “removed” by checking the appropriate box.
- 3. COVERAGE SELECTION** – Select the coverage for which you (and/or your dependents) are applying or to which you are changing. If you are adding a product and 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, or “R” to remove in the column. If you are unsure which types of coverage you now have, or are eligible to 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 intend to apply for Keystone Health Plan Central’s SeniorBlue program, please call 1-800-669-7061.
- 4. PRIMARY CARE PHYSICIAN (PCP)** – PCP selection requirements vary by product. The following products involve PCP selection:
 - With *PPO+* coverage, selection of a PCP is *voluntary*, and specialty care from participating providers may be accessed directly, without a PCP referral.
 - With *POS* coverage, selection of a PCP is required, and in order to obtain the highest level of benefits, the selected PCP must provide referrals for non-emergency, specialty, and other care.
 - With *HMO* coverage, selection of a PCP is required, and the selected

PCP must provide referrals for non-emergency, specialty and other care. Print your PCP group practice name and group PCP code number (found in your Capital BlueCross Provider Directory or Keystone Health Plan Central Provider Directory or on our Web site—www.capbluecross.com). You and each member of your family can select his or her own PCP from the Directories or Web site listing. The Directory or Web site 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 PCP.

- 5. 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.
- 6. 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 appropriate box to indicate whether you or any of your dependents are classified as Disabled under Medicare or eligible for Medicare benefits due to End Stage Renal Disease (ESRD).
- 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 19 years of age or older and a full-time student at an accredited school or university. Print the Name of the dependent(s), the Name of the school or university, and the anticipated Graduation Date(s).
- 9. CHANGE INFORMATION** – Complete this section to make a change in Name, Social Security Number, or Birth Date for you or a dependent. Mark the appropriate box to indicate if the change is for you or the dependent. Print the current information in the “FROM” block and the new or correct information in the “TO” block.
- 10. 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.

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

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.
1. SUBSCRIBER INFORMATION:

Subscriber Identification _____		Birth Date / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Subscriber Name (Last, First, M.I.) _____				<input type="checkbox"/> Single <input type="checkbox"/> Married	
Mailing Address (Include street address, city, state and ZIP Code) _____			New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			County _____		
Home Phone Number () _____		Work Phone Number / Ext. () _____		Email Address _____	
Employment Status: <input type="checkbox"/> Active (Full-Time) <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Active (Part-Time) <input type="checkbox"/> Salary <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union					
				Average Number of Hours Worked Per Week _____	

Employer's Name _____		
Group Name (if different from above) _____		
Group Number _____	Subgroup Number _____	Class _____
Does your company employ 20 or more employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer's Address (for Association Groups Only) _____		Member Firm ID _____
		Eff Date of Above _____
Effective Date of Coverage/Change: / /		
Date Hired / /	Has waiting period been met? <input type="checkbox"/> Yes <input type="checkbox"/> No	
TYPE OF ACTIVITY		
<input type="checkbox"/> Enrollment <input type="checkbox"/> Change of Enrollment <input type="checkbox"/> Termination		
REASON CODES (See back for codes and descriptions)		
<input type="checkbox"/> Open Enrollment		
<input type="checkbox"/> Life Status Change:	CODE _____	Date of Change / /
<input type="checkbox"/> Initial Eligibility Change:	CODE _____	Date of Change / /
<input type="checkbox"/> Termination:	CODE _____	Date of Change / /
<input type="checkbox"/> Other (Please Explain) _____		

2. ENROLLMENT/CHANGE INFORMATION

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	PPO	PPO+	POS	HMO	Senior	Dental	Vision	Drug
SUBSCRIBER			<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> Son <input type="checkbox"/> Dau		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
<input type="checkbox"/> Other		/ /	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE										
Dependent Address if different from Subscriber _____				Place an "A" to ADD Coverage or an "R" to REMOVE Coverage For the issuer(s) of these coverages, please see reverse side.				PCP selection required for POS and HMO, optional for PPO+.					

3. COVERAGE SELECTION/CHANGE
4. PRIMARY CARE PHYSICIAN
5. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent _____

6. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. (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)		Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	ESRD? <input type="checkbox"/> Yes <input type="checkbox"/> No
			Hospital (Part A)	Medical (Part B)		
			/ /	/ /		

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 19 YEARS OLD OR OLDER and enrolled as full-time students 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 Date of Graduation
		/ /

9. CHANGE THE FOLLOWING INFORMATION

Change is for Subscriber Dependent (Name)

Name	From _____	To _____
Birth Date	From / /	To / /
Social Security Number	From _____ / _____ / _____	To _____ / _____ / _____

10. 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 _____



Capital BlueCross

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

1-800-962-2242

www.capbluecross.com



Keystone HEALTH PLAN CENTRAL A Capital BlueCross Company

1-800-669-7061

GROUP ADMINISTRATOR: Please complete shaded area of form

Employer's Name, Group Name, Group Number, Subgroup Number, Class, Does your company employ 20 or more employees?, Employer's Address, Member Firm ID, Eff Date of Above, Effective Date of Coverage/Change, Date Hired, Has waiting period been met?, TYPE OF ACTIVITY, REASON CODES, Open Enrollment, Life Status Change, Initial Eligibility Change, Termination, Other (Please Explain)

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION:

Subscriber Identification, Birth Date, Male/Female, Subscriber Name, Single/Married, Mailing Address, New Address?, County, Home Phone Number, Work Phone Number, Email Address, Employment Status, Average Number of Hours Worked Per Week

2. ENROLLMENT/CHANGE INFORMATION

First Name & Middle Initial, Social Security Number, Birth Date, ADD or REMOVE?, Trad., Comp., PPO, PPO+, POS, HMO, Senior, Dental, Vision, Drug, PCP Code #, Current Patient?

3. COVERAGE SELECTION/CHANGE

ADD or REMOVE?, Trad., Comp., PPO, PPO+, POS, HMO, Senior, Dental, Vision, Drug, PCP Code #, Current Patient?

4. PRIMARY CARE PHYSICIAN

Indicate Practice Names & Codes (Refer to Applicable Provider Directory), PCP Code #, Current Patient?

5. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

6. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Name of Subscriber or Dependent, Medicare Claim Number, Effective Date(s), Hospital (Part A), Medical (Part B), Disabled?, ESRD?

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with any other insurance company. 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 19 YEARS OLD OR OLDER and enrolled as full-time students at an accredited school or college/university. Student's Name, Name of School or College/University, Expected Date of Graduation

9. CHANGE THE FOLLOWING INFORMATION

Change is for, Name, Birth Date, Social Security Number, From, To

10. 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

INITIAL ELIGIBILITY:

<u>Code</u>	<u>Definition</u>
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 :	The Association acquires a new employer group.
E :	Union member now eligible for coverage.

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

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

SUBSCRIBER TERMINATIONS (Including all dependents):

<u>Code</u>	<u>Definition</u>
01 :	The subscriber is no longer employed/requests cancel.
03 :	The subscriber is deceased.
04 :	The contract cancel reason is unknown.
05 :	The subscriber has coverage with another Blue plan.
33 :	The subscriber selected coverage through another insurance company.

DEPENDENT TERMINATIONS:

<u>Code</u>	<u>Definition</u>
03 :	The dependent is deceased.
05 :	The dependent has coverage with another Blue plan.
08 :	The dependent marries.
09 :	The dependent is over the age limit.
10 :	The dependent is divorced.
11 :	The dependent is separated.
33 :	The dependent has coverage through another insurance company.

OTHER/EXPLANATION:

If the reason for the enrollment/change 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 Primary Care Physician, 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.

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