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

GROUP ADMINISTRATOR - You must complete all shaded areas 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/Change 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**.

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

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

INSTRUCTION SHEET

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

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. If Retired, enter the retirement start Date. If your Employment Status is not one of the choices listed, please complete the Other (Explain) field. 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 *Plus* 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 nonemergency, specialty, and other care.
   - With *HMO* coverage, selection of a PCP is required, and the selected PCP must provide referrals for nonemergency, 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. **MEDICARE COVERAGE 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 19 years of age or older and 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. **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.

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

1-800-962-2242 www.capbluecross.com 1-800-669-7061

GROUP ADMINISTRATOR: You must complete all shaded areas 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 | Effective Date of Above

Effective Date of Coverage/Change: / /

Date Hired: / / | Has waiting period been met? ☐ Yes ☐ No

TYPE OF ACTIVITY

☐ Enrollment ☐ Change of Enrollment ☐ Termination

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

☐ Open Enrollment
☐ Initial Eligibility Change: CODE Date of Change / /
☐ Life Status Change: CODE Date of Change / /
☐ Termination: CODE Date of Change / /
☐ Other (Please Explain) Date of Change / /

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 (Last, First, M.I.) | ☐ Single ☐ Married

Mailing Address (Include street address, city, state and ZIP Code) | New Address? ☐ Yes ☐ No | County

Home Phone Number ( ) | Work Phone Number / Ext. ( ) | 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/CHANGE INFORMATION | 3. COVERAGE SELECTION/CHANGE | 4. PRIMARY CARE PHYSICIAN

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	PPO	PPO Plus	POS	HMO	Senior	Dental	Vision	Drug	Indicate Practice Names & Codes (Refer to Applicable Provider Directory)
SUBSCRIBER			☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Other		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No

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 *Plus*.

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): Hospital (Part A)	Effective Date(s): Medical (Part B)	Reason/Effective Date for Medicare coverage: ☐ 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 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 Graduation Date
		/
		/

9. CHANGE THE FOLLOWING INFORMATION

Change is for ☐ Subscriber ☐ Dependent (Name)

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

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 ________

NF-2 (3/2006)

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

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

1-800-962-2242 www.capbluecross.com 1-800-669-7061

GROUP ADMINISTRATOR: You must complete all shaded areas 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	
	Effective Date of Above	
Effective Date of Coverage/Change: / /		
Date Hired: / /	Has waiting period been met? ☐ Yes ☐ No	

TYPE OF ACTIVITY

☐ Enrollment ☐ Change of Enrollment ☐ Termination

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

☐ Open Enrollment		
☐ Initial Eligibility Change:	CODE	Date of Change / /
☐ Life Status Change:	CODE	Date of Change / /
☐ Termination:	CODE	Date of Change / /
☐ Other (Please Explain)		Date of Change / /

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 (Last, First, M.I.)		☐ Single ☐ Married
Mailing Address (Include street address, city, state and ZIP Code)	New Address? ☐ Yes ☐ No	County
Home Phone Number ( )	Work Phone Number / Ext. ( )	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/CHANGE INFORMATION 3. COVERAGE SELECTION/CHANGE 4. PRIMARY CARE PHYSICIAN

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	*PPO*	PPO *Plus*	*POS*	*HMO*	*Senior*	Dental	Vision	Drug	Indicate Practice Names & Codes (Refer to Applicable Provider Directory)
SUBSCRIBER			☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Other		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No

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 *Plus*.

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 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 Graduation Date
		/
		/

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 ______________

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

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 :	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):

Code	Definition
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 has a change in his/her Medicare Primary Status (e.g., the employee retires and Medicare becomes 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):

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 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.