

A. REASON FOR APPLICATION

Date of Event Checked: 07/01/2017

ADD DEPENDENTS DUE TO:

CANCEL DEPENDENTS DUE TO:

- New coverage
- Change coverage
- Information change
- Refuse coverage (see Section F)

- Marriage/Civil Union
- Non-voluntary coverage loss
- Birth Adoption / Guardianship
- Other

- Divorce
- Over age
- No longer dependent
- Death
- Other

B. PERSONAL

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Non-employee	Date of Retirement (month / day / year)	Social Security Number	Agency		
<input type="checkbox"/> Female	<input type="checkbox"/> Surviving spouse				PENSION OFFICE		
Last Name		First Name		M.I.	Date of Birth (month / day / year)	Home Phone (include area code)	Business Phone (include area code)
Street Address						City	State Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR:

- Individual
- Individual & Spouse
- Individual & Child(ren)
- Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse
Relationship of Child/Dependent applies to Child/Dependent(s) and/or Civil Union Child/Dependent(s)

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

- Highmark Delaware First State Basic PPO Plan
- Highmark Delaware Comprehensive PPO Plan
- Aetna HMO Plan
- Aetna Consumer Directed Health (CDH) Gold Plan

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose or Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.**

Name of Your Primary Care Physician				Physician's ID Number		Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? <input type="checkbox"/> Y <input type="checkbox"/> N
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F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Delaware or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis,

treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

I elect **NOT** to participate in the State Health Insurance.

Signature: _____ Date: _____

Signature: _____ Date: _____