HIGHMARK
HEALTH INSURANCE COMPANY

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

❑ ENROLLING
(Complete sections I, II, IV, and V)

❑ WAIVING
(Complete sections I and III)

I. APPLICANT INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

Last Name	First Name	MI	Social Security No.	Marital Status (Please check one):
			— —	❑ Single/Widowed ❑ Married ❑ Divorced

Address

City	State	Zip	County	Home/Cell Phone

Enrollment Status	Date of Full-Time Hire or Rehire	Hours Worked Per Week
❑ Active Employee ❑ Rehired Employee ❑ COBRA/mini-COBRA ❑ Act 4 Dependent	Mo Day Yr	

❑ COBRA/mini-COBRA
Start Date _____ End Date _____

COBRA/mini-COBRA REASON: ❑ Deceased ❑ Involuntary Lay-Off ❑ Left Employment
❑ Other _____ Date of Event _____

II ENROLLMENT INFORMATION AND COVERAGE SELECTION (If additional space is required, attach a separate sheet)

APPLICANT

Sex	Date of Birth (Month/Day/Year)	Dependent Status if over Age 26 ❑ Act 4
❑ Male ❑ Female	/ /	If Act 4 Dependent, provide: Employee (parent) Name _____ and Social Security No. — —

Product Selection: ❑ Medical _____ ❑ Vision ❑ Dental

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___/___/___ (Month/Day/Year)

DEPENDENT #1

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Dom. Part.

Social Security Number (If no SS#, write N/A)	Sex	Date of Birth (Month/Day/Year)
— —	❑ Male ❑ Female	/ /

Product Selection: ❑ Medical _____ ❑ Vision ❑ Dental

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___/___/___ (Month/Day/Year)

DEPENDENT #2

First Name	MI	Last Name	Relationship to You?
			❑ Child ❑ Step-child ❑ Other*

Social Security Number (If no SS#, write N/A)	Sex	Date of Birth (Month/Day/Year)
— —	❑ Male ❑ Female	/ /

Product Selection: ❑ Medical _____ ❑ Vision ❑ Dental	Dependent Status if over Age 26 ❑ Disabled

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___/___/___ (Month/Day/Year)

*If "other" applies, complete using one of the following codes: (02) Adopted Child, (03) Court Appointed Guardian, (05) Grandchild, or (07) Nephew or Niece. Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this Application if relationship is other, and may be required in other instances.

DEPENDENT #3

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Other*
Social Security Number (If no SS#, write N/A) — —		Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /
Product Selection: ❑ Medical _____ ❑ Vision ❑ Dental			Dependent Status if over Age 26 ❑ Disabled

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? _____ / _____ / _____ (Month/Day/Year)

DEPENDENT #4

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Other*
Social Security Number (If no SS#, write N/A) — —		Sex ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /
Product Selection: ❑ Medical _____ ❑ Vision ❑ Dental			Dependent Status if over Age 26 ❑ Disabled

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? _____ / _____ / _____ (Month/Day/Year)

*If "other" applies, complete using one of the following codes: (02) Adopted Child, (03) Court Appointed Guardian, (05) Grandch ld, or (07) Nephew or Niece. Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this Application if relationship is other, and may be required in other instances.

III WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s))

EMPLOYEE MUST SIGN BELOW

MEDICAL		VISION	DENTAL
I HEREBY DECLINE MEDICAL COVERAGE: ❑ For myself ❑ For family members ONLY: ❑ For myself and ALL family members ❑ For the following family members: _____	REASON FOR DECLINING MEDICAL COVERAGE: ❑ Insured under spouse's contract with the following insurance carrier: _____ ❑ Other: _____	I HEREBY DECLINE VISION COVERAGE: ❑ For myself ❑ For family members ONLY ❑ For myself and ALL family members ❑ For the following family members: _____	I HEREBY DECLINE DENTAL COVERAGE: ❑ For myself ❑ For family members ONLY ❑ For myself and ALL family members ❑ For the following family members: _____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Employee Signature _____ Date _____

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV ABOUT OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policy Holder
Policy Holder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ❑ Active ❑ Retired - List Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: EMPLOYEE MUST SIGN BELOW

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark Health Insurance Company and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

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 acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

Print Company Name

Employee Signature

Date

Print Employee's Name

For New Business:
Highmark Health Insurance Company
Small Group Sales
120 Fifth Avenue, Suite P2504
Pittsburgh, PA 15222