22259

SMALL GROUP ENROLLMENT/CHANGE FORM

HIGHMARK WEST VIRGINIA

☐ **ENROLLING**
(Complete sections I, II, IV, and V)

☐ **WAIVING**
(Complete sections I and III)

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental Application from your Group Administrator.

I. EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location

REASON FOR COMPLETION:
☐ New Enrollee ☐ Changes ☐ Rehire
☐ COBRA/mini-COBRA ☐ Cancel Contract
Start Date _____
End Date _____
(Please attach a copy of COBRA Election Notice.)

DEPENDENT CHANGES:
Add dependent(s) due to:
☐ Birth ☐ Marriage ☐ Adoption
Date of Above Event _____
(Please attach a copy of HIPAA Certificate, if applicable.)
Cancel dependent(s) due to:
☐ Divorce ☐ Death ☐ Other _____

Date of Above Event _____
OTHER CHANGES:
☐ New Name
☐ New Address
☐ Change to Medicare Eligible
☐ Change Coverage (HIPAA Life Event)
☐ Other _____
Date of Above Event:

CANCEL REASON/ COBRA REASON FOR CONTRACT HOLDER:
☐ Deceased ☐ Left Employment ☐ Involuntary Lay-Off ☐ Other Coverage ☐ Other_____ Date of Event _____

First Name	MI	Last Name	Social Security No.	Date of Birth (Month/Day/Year)	Age

Street Address	Gender	Marital Status (Please check one):
	☐ Male ☐ Female	☐ Single / Widowed ☐ Married ☐ Divorced

City	State	Zip	County	Home/Cell Phone	Email Address

Employment Status	Date of Full-Time Hire or Rehire			Hours Worked Per Week	Job Title
☐ Active ☐ Rehire ☐ COBRA/mini-COBRA ☐ Retired	Mo	Day	Yr		

Product Selection: ☐ Medical Product Name: ☐ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		☐ Yes ☐ No

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

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			☐ Spouse[1] ☐ Domestic Partner[2]

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
	☐ Male ☐ Female		

Product Selection: ☐ Medical Product Name: ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		☐ Yes ☐ No

[1] If spouse 's last name differs from the contract holder, please include a copy of marriage certificate.
[2] If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

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

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26
	☐ Male ☐ Female			☐ Disabled**

Product Selection: ☐ Medical Product Name: ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient?
		☐ Yes ☐ No

DEPENDENT CHILD

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

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26
	❑ Male ❑ Female			❑ Disabled**

Product Selection: ❑ Medical Product Name: ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient?
		❑ Yes ❑ No

DEPENDENT CHILD

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

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26
	❑ Male ❑ Female			❑ Disabled**

Product Selection: ❑ Medical Product Name: ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient?
		❑ Yes ❑ No

*Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this application if the relationship is Adopted or Other.

**Highmark WV Disabled Dependent Adult Verification Eligibility Form must be attached to this application for review.

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

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. 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.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

_____ Employee/Contract Holder Signature (please hand sign if this is a paper request)

_____ 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 or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Blue Cross Blue Shield West Virginia Member Service number: 1-888-809-9121 (TTY/TDD: Dial 711).

IV. OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage (If additional space is required, attach a separate sheet)

Name of Insurance Carrier	Policy Number	Group Number	Effective Date

Name of Policy Holder	Policy Holder Date of Birth	Relationship to Policy Holder	Policyholder Employment Status
			❑ Active ❑ Retired
Cancel Date	**Cancel Reason**		Date of Retirement:

List all covered dependents: _____

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 have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or recision of coverage and may subject me to legal action by Highmark WV. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Highmark WV unless and until this Application for coverage is approved and I have been provided an Effective Date and Group Number, and only as long as the Group continues to qualify under the terms of the Group contract with Highmark WV, including timely payment of premiums.

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 WV may use and disclose Protected Health Information for payment and treatment of health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark WV Notice of Privacy Practices is available on the Highmark WV Web site, or from the Highmark WV Privacy Office.

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark WV 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.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Print Employer/Group Name

Employee/Contract Holder Signature (please hand sign if this is a paper request) Date

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

SALES RECEIVED DATE	ENROLLMENT & BILLING RECEIVED DATE	UNDERWRITING RECEIVED DATE

SEND TO:

For New Business
Highmark West Virginia
Attn: Sales
P.O. Box 1948
Parkersburg, WV 26102
Fax: (304) 424-0323

For Changes
Highmark West Virginia
Attn: Enrollment & Billing
P.O. Box 1948
Parkersburg, WV 26102
Fax: (866) 251-0741
Email: WVMembership@highmark.com

Coverage Effective Date _____

Date Approved _____

Date Denied _____

Approved By _____

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4110.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.