



MEMBER CHANGE FORM

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

EMPLOYEE/CONTRACT HOLDER INFORMATION

Effective Date	Employer/Group Name	Group Number	Payroll Location
REASON FOR COMPLETION: <input type="checkbox"/> Enrollment Changes <input type="checkbox"/> Cancel Entire Contract <input type="checkbox"/> COBRA Continuant Start Date _____ (Please attach a copy of COBRA Election Notice.)		DEPENDENT CHANGES: Add dependent(s) due to HIPAA Life Event: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____ Date of Above Event _____ (Please attach a copy of HIPAA Certification Form.) Cancel dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	
		OTHER CHANGES: <input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage Date of Above Event _____	

CANCEL Reason for Contract Holder:
 Deceased Left Employment Involuntary Lay-Off Other Coverage Other _____ Date of Above Event _____

Additional Comments:

First Name	MI	Last Name	Home/Cell Phone		
Address		City	State	Zip	County
Date of Birth (Month/Day/Year) / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled		Social Security Number (If no SS#, write N/A)
Product Selection(s) <input type="checkbox"/> Medical Product Name _____ <input type="checkbox"/> Dental					

COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]		
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /		Age
Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Dental					

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.
[†]If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*		
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /		Age
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Dental			

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Dental		

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First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Dental		

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

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

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

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 _____

Highmark Blue Cross Blue Shield West Virginia is an independent licensee of the Blue Cross and Blue Shield Association.

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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.