

APPLICATION FOR NEW GROUPS ENROLLING 2–50 SUBSCRIBERS

Dependable Health Care Coverage from the Capital BlueCross Family of Companies

GROUP ADMINISTRATOR – You must complete all areas in the Group Administrator Box 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 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.

REASON CODES (For Group Administrator Use) – Place a check mark in the appropriate box to indicate the reason for completing the application—Open Enrollment or Initial Eligibility. Enter the appropriate code and date for the enrollment. Refer to the back of the application for appropriate codes and descriptions.

INSTRUCTIONS TO SUBSCRIBER

IMPORTANT: Print clearly and complete this form accurately to help us process your enrollment information as quickly as possible. If you have any questions about completing the Enrollment 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).

Please send the completed application to:

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

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.

INSTRUCTION SHEET

1. **SUBSCRIBER INFORMATION** – If you 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/Cell and Work Phone Numbers, including Extension (required in the event Capital BlueCross needs to notify the enrollee of benefit information). 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.

2. **ENROLLMENT 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. If the spouse or dependent's address is different from the Subscriber's due to a Qualified Medical Child Support Order (QMCSO), a copy of the court order is required (along with the alternate address) to process the address change. Provide this information to your Group Administrator to submit with this application. If the address is different due to Act 150 (The Spousal and Child Medical Support Act 150 of PA), contact Customer Service (the numbers are listed on this application) so the appropriate forms may be mailed to you. Be sure to have the form notarized before returning it to us.

3. **COVERAGE SELECTION** – Select the coverage for which you (and/or your dependents) are applying. When 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, in the column. If you are unsure which types of coverage you may 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 are eligible for Medicare coverage and intend to apply for enrollment in one of our Medicare plan options, please call 1-800-976-2242.

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 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. **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.

10. **DISCLOSURE AUTHORIZATION FORM** – Before completing the Disclosure Authorization Form, remove the tissue paper, sign and date the appropriate fields, and retain a copy for your records. Please remember we must have a signature for every family member choosing to enroll – including your spouse and every dependent. If the dependent is 18 or older, the dependent's signature is required. If the dependent is under age 18, a parental signature is required. A qualified "personal representative" under HIPAA may sign on behalf of a Member.

Tear off this page and use it to help you complete this form. Then discard.

Use this application for initial enrollment of new groups enrolling 2-50 subscribers and the instances listed below:

INITIAL ELIGIBILITY:

Code Definition

- A : New group enrollment.
- 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.

For enrollment changes (i.e., address change, removing dependents, or terminating coverage) complete the *Application to Enroll or Change Enrollment Form (NF-2)*.

OTHER/EXPLANATION:

If the reason for the enrollment 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.

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DISCLOSURE AUTHORIZATION FORM

Please be sure to remove the tissue paper before completing this form.

By signing this form, I authorize Capital BlueCross to collect and process my individually identifiable health information described below so that Capital BlueCross has the information it needs to determine the premium to be charged to my employer, and to conduct clinical management activities if I enroll in Capital BlueCross coverage.

By signing this form, I also authorize the insurers and health plans that have covered me in the past, and pharmacy benefit managers and reinsurers that have performed services for the insurers and health plans that have covered me in the past, to disclose claims records and other health information. Such information may include information protected by state law including, but not limited to, HIV, mental health, and substance abuse.

I understand the nature of this release and I understand that I can refuse to sign this authorization. Capital BlueCross will not refuse to enroll me or deny me benefits if I refuse to sign this form. This form does not apply to and I do not authorize disclosure of psychotherapy notes. I understand that, with respect to any of the parties described above, I may revoke this authorization at any time. To revoke the authorization for any of the parties named above, I understand that I must give written notice to that party, and that to revoke the authorization for all parties, I must give written notice to each of my former insurers, health plans, pharmacy benefit managers, and reinsurers, in addition to Capital BlueCross. My revocation will not affect the rights of anyone who has acted in reliance on the authorization prior to receiving notice of my revocation. Unless revoked earlier, this authorization will be valid until the initial underwriting determination is made by Capital BlueCross. I understand that the information covered by this form, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

GROUP INFORMATION

Group Name:	Group ID Number:
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AUTHORIZATION SIGNATURES

Print Name of Proposed Insured	Signature of Proposed Insured (Subscriber or Subscriber's Personal Representative†)	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Spouse or Spouse's Personal Representative†)	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date
Print Name of Proposed Insured	Signature of Other Proposed Insured (Signature of Dependent or Dependent's Personal Representative†)*	Date

†An individual's personal representative includes an individual's legal guardian, or someone who has power of attorney over the individual's health care decisions. A copy of the power of attorney or other court initiated documents should be included along with this form, if applicable.

* If the dependent is 18 or older, the dependent's signature is required. If the dependent is under age 18, a parental signature is required. A qualified "personal representative" under HIPAA may sign on behalf of a Member.